Tameside Metropolitan Borough

ASHTON-UNDER-LYNE · AUDENSHAW · DENTON · DROYLSDEN · DUKINFIELD · HYDE · LONGDENDALE · MOSSLEY · STALYBRIDGE

SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 6 December 2016
Time: 2.30 pm
Place: New Century House, Progress Way, Windmill Lane, Denton, M34 2GP

Item No.	AGENDA	Page No
1.	**WELCOME & APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Single Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the minutes of the previous meeting held on 1 November 2016.	1 - 8
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the report of the Director of Finance, Single Commissioning.	9 - 28
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the report of the Director of Public Health and Performance, Single Commissioning.	29 - 82
6.	**COMMISSIONING FOR REFORM**	
a)	**HOME START HOME VISITING AND BEFRIENDING SERVICE AND TWO YEAR OLD FREE EARLY EDUCATION ENTITLEMENT SUPPORT** To consider the attached report of the Director of Public Health and Performance, Single Commissioning.	83 - 88
b)	**CONTRACT FOR THE PROVISION OF A BREASTFEEDING PEER SUPPORT SERVICE** To consider the attached report of the Director of Public Health and Performance, Single Commissioning.	89 - 92

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

7. URGENT ITEMS

To consider any items which the Chair is of the opinion shall be considered as a matter of urgency in accordance with legal provisions as set out in the Local Government Act 1972 (as amended).

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Tuesday 17 January 2017 commencing at 3.00 pm, in the Lesser Hall, Dukinfield Town Hall.

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

TAMESIDE AND GLOSSOP
CARE TOGETHER SINGLE COMMISSIONING BOARD

1 November 2016

Commenced: 2.30 pm **Terminated: 4.10 pm**

PRESENT: Alan Dow (Chair) – Tameside and Glossop CCG
Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer, Tameside and Glossop CCG
Richard Bircher – Tameside and Glossop CCG
Christina Greenhough – Tameside and Glossop CCG
Graham Curtis – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC

IN ATTENDANCE: Aileen Johnson – Head of Legal Services
Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Ali Rehman - Public Health
Anna Moloney – Public Health

APOLOGIES: Councillor Gerald P Cooney – Tameside MBC

87. DECLARATIONS OF INTEREST

There were no declarations of interest submitted by Members of the Board.

88. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 4 October 2016 were approved as a correct record.

89. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance, Single Commissioning Team, presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial positon of the economy. It provided a 2016/17 financial year update on the month 6 financial position at 30 September 2016 and the projected outturn at 31 March 2017.

It was explained that the report included components of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2016/17 financial year.

The 2016/17 financial year was particularly challenging due to the significant financial gap and the risk of CCG QIPP schemes not being sufficiently developed to deliver the required level of efficiencies in the year. Work was continuing to deliver improvement on the CCG QIPP position following submission of the recovery plan.

Members of the Board noted a summary of the financial position of the Tameside Hospital NHS Foundation Trust which provided an awareness of the overall financial position of the whole Care Together economy and highlighted the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.

In terms of a financial summary, it was explained that there was a clear urgency to implement associated strategies to ensure the projected funding gap was addressed and closed on a recurrent basis across the whole economy. Each constituent organisation would be responsible for the financing of their resulting deficit at 31 March 2017.

It was noted that additional non recurrent budget had been allocated by the Council to Adult Services (£8 million) and Childrens' Services (£4 million) in 2016/17 to support the transition towards the delivery of a balanced budget within these services during the current financial year.

RESOLVED

(i) That the 2016/17 financial year update on the month 6 financial position at 30 September 2016 and the projected outturn at 31 March 2017 be noted.

(ii) That the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget be acknowledged.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be acknowledged.

90. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health and Performance providing an update on CCG assurance and performance based on the latest published data. The August position was shown for elective care and an October snap shot in time for urgent care. Also attached was a CCG NHS Constitution scorecard showing CCG performance across indicators. It also included referral data and a section on care homes.

The assurance framework for 2016/17 had been published nationally. However, the framework from GM Devolution was still awaited.

Particular reference was made to the following matters:

- Performance issues remaining around waiting times in diagnostics and the A & E performance;
- The number of patients still waiting for treatment 18 and over continued to decrease and the risk to the delivery of incomplete standard and zero 52 week waits was being reduced;
- Cancer standards were achieved in August and Quarter 1 performance achieved;
- Endoscopy was still the key challenge in diagnostics particularly at Central Manchester;
- A & E standards were failed at Tameside Hospital Foundation Trust;
- Attendances and NEL admissions at Tameside Hospital Foundation Trust (including admissions via A & E) had increased;
- The number of Delayed Transfers of Care recorded remained higher than planned; and
- Ambulance response times were not met at a local or at North West level.

RESOLVED

(i) That the 2016/17 CCG Assurance position be noted.

(ii) That the current levels of performance be noted.

91. COMMISSIONING INTENTIONS 2017-19

The Director of Commissioning submitted a report outlining the approach taken to the development of the Tameside & Glossop Commissioning Intentions for 2017-19. A draft commissioning intentions letter was appended to the report, which, once approved, would be shared with all providers.

It was explained that the commissioning intentions had been developed in line with national NHS planning and contract guidance, including the requirement that commissioning is on a 2 year basis for 2017-19.

RESOLVED

(i) That the approach taken to the development of the Tameside & Glossop commissioning intentions for 2017-19 be endorsed; and

(ii) That the letter appended to the report be approved and that it be shared with providers in line with the NHS England contract timetable.

92. MENTAL HEALTH COMMISSIONING INTENTIONS

RESOLVED

That this item be deferred to the next meeting of the Board.

93. WHEELCHAIR SERVICES

Consideration was given to a report of the Director of Commissioning, which explained that NHS Tameside & Glossop CCG currently commissioned wheelchair assessment and provision services from Stockport NHS Foundation Trust. This was formerly part of the community contract with Stockport NHS Foundation Trust, but the service did not transfer to Tameside NHS Foundation Trust on 1 April 2017 due to the joint commissioning and provision arrangements with 2 other CCGs. Oldham CCG was party to the Tameside & Glossop CCG contract for this service. Stockport CCG contract separately but for the same service.

It was reported that, prior to 31 March 2016, the funding arrangements were as follows:

- NHS Oldham CCG £466,572
- NHS Tameside & Glossop CCG £1,050,568
- NHS Stockport CCG £1,090,146

All three CCGs had comparable levels of activity despite the different level of investment.

Board members were informed that the contract currently in place between Tameside & Glossop CCG (Including Oldham CCG) was due to expire on 31 March 2017. Proposals for the commissioning of a wheelchair service (assessment and provision) including the procurement of a new service to start from April 2017, were set out in the report.

In respect of negotiations for 2016-17 contract, it was reported that, in light of the imbalance between the levels of investments, Tameside & Glossop CCG negotiated a reduction in the contract for 2016-17 from £1,050m to £821k, therefore achieving a recurrent Quality and Innovation Productivity and Prevention (QIPP) of £229k. This had been included in the financial recovery plan submitted to NHSE on 9 September as a recurrent saving.

With regard to the financial envelope for the new service, NHS England would be publishing a wheelchair report imminently. This would include currencies for use, but would not include a specific tariff, as NHS England needed to improve their reference costs and would change their guidance when this data was available. Therefore that was no national tariff on which the cost of/budget for a wheelchair service could be based.

In the absence of a national tariff, benchmarking of the cost of wheelchair services had been undertaken by the commissioning and finance staff in the Single Commission. Commissioners had determined that a new service, which met the national standards and requirement for the population of Tameside & Glossop could be commissioned with a budget of £600,000 per year.

In respect of potential co-commissioning with Oldham CCG, Oldham CCG had provisionally confirmed their initial intention to continue to be a party to the contract for wheelchair services going forward. However, as an equitable budget could not be agreed, it was anticipated that Tameside & Glossop CCG would undertake the procurement solely for the population of Tameside & Glossop. It would be a matter for Oldham as to how they then proceeded.

Board members were informed that a draft service specification had been produced and consultation commenced (including an Equality Impact Assessment and Quality Impact Assessment) with a view to using this specification as the basis for the re-procurement. Partners in existing provider organisations had been involved in the development of the specification, including representatives from Tameside & Glossop ICFT.

Whilst Tameside & Glossop ICFT were willing to provide support for the procurement process to ensure the service would fit in with the aims and objectives of Tameside & Glossop ICFT, this would not be permitted to delay the re-tendering of this service given the financial and operational imperatives for the service to be in place by 1 April 2017.

RESOLVED

(i) That the Single Commissioning Board endorse the service of notice on the Stockport NHS Foundation Trust wheelchair contract to take effect on 31 March 2017.

(ii) **That the Single Commissioning Board agree that;**

- **The Single Commission will seek to negotiate additional savings for the economy whilst having due regard for the recovery, health and welfare of those in need of the service;**
- **The Single Commission will continue to work with stakeholders on the finalisation of a service specification for wheelchair services. The specification will be in line with national guidance and will be subject to all necessary Impact Assessments;**
- **The Single Commission will work with Tameside and Glossop Integrated Care Foundation Trust to ensure the service is used effectively; and**
- **The Single Commission will use the Shared Business Services framework to retender and procure the new wheelchair services (inc. assessment and provision) to take effect from 1 April 2017.**

94. COMMISSIONING OF INTEGRATED COMMUNITY EQUIPMENT SERVICES

The Director of Commissioning submitted a report explaining that the Integrated Community Equipment Service (ICES) supplied equipment to Tameside and Glossop residents prescribed by occupational therapists, physiotherapists and community nurses. The service operated a store of equipment that was supplied directly to service user's homes and to peripheral stores for use by prescribers. The service also collected an recycled equipment no longer required.

It was reported that the ICES was provided under contract by Ross Auto Engineering Limited trading as Rosscare and the current contract would conclude on 30 September 2017 necessitating a procurement exercise to ensure a new service is in place form this date.

Rochdale and Oldham Boroughs, who also currently use the same provider (Rosscare), had expressed an interest in a joint procurement exercise.

Board members were further informed that a minor adaptations service, providing grab rails, stair rails and key safes, would conclude on 31 December 2016. It was explained that the service could easily be integrated into the ICES service as it was provided for the same client group and specified by the same practitioners. To integrate the service, permission was sought to extend the contract for up to 3 months to facilitate consultation under TUPE and to make a direct award to Rosscare for the minor adaptations service, co-terminus with the ICES contract and for the service to be incorporated within the ICES when reprocured.

In respect of proposals for future commissioning arrangements, Board members were asked to agree to further discussions with Tameside & Glossop ICFT to propose the transfer of the budget and contract responsibilities for community equipment (2017-20) to Tameside & Glossop ICFT once a contract had been awarded to a provide to provide the service from October 2017. This

would include the transfer of the remaining budget and all contract/performance management responsibilities.

RESOLVED

(i) That the continued allocation of finance of £1.7 million for the combined ICES and minor adaptations service be approved;

(ii) That a joint procurement with other local commissioners for a contract of 3+2 years be approved;

(iii) That the required waivers and authorisation to proceed with the proposals as detailed in the report be approved; and

(iv) It be noted that further discussions were to be held with commissioners and Tameside and Glossop Integrated Care NHS FT to propose the transfer of the future contract (2017-20) to Tameside & Glossop ICFT (to include transfer of the remaining budget and all contract/performance management responsibilities).

95. HIV PREVENTION SERVICES

A report of the Director of Public Health was submitted seeking agreement to continue the financial commitment to HIV Prevention and Support services until 31 March 2019. It was explained that current services were commissioned under joint arrangements for Greater Manchester Authorities by Manchester City Council. This request related to the services delivered by the following providers:

- Lesbian Gay Bisexual and Transgender Foundation (LGBTF)
- George House Trust (GHT)
- BHA Equalities (BHA)

The report detailed the proposed future commissioning intentions for HIV Prevention and Support Services and continued collaborative commissioning arrangements with the other areas in Greater Manchester (GM). The proposal was to consolidate the existing provision across Greater Manchester into a more streamlined service(s) that was responsive to the needs of the most at risk of HIV. Salford City Council was proposing to be the lead commissioner of these services on behalf of Greater Manchester Authorities with support from the Greater Manchester Sexual Health Network (GMSHN).

Board members were informed that the economy currently invested £22,560 per annum in Sexual Health HIV prevention across these three voluntary sector providers. This was the smallest amount invested by any Local Authority across Greater Manchester. Protecting the funding was important as it both funded the delivery of services to some of the most vulnerable and high risk population in terms of sexual health needs and gave access to the wider Manchester City region investment in these services. The continued commitment to this level of funding would maintain the economies of scale received by collaboratively commissioning across Greater Manchester.
It was explained that the current lead commissioner, Manchester City Council, had authority to extend current contracts until 31 March 2019 with contracts due to expire on 31 March 2017. They were seeking agreement from Greater Manchester partners to continue the current arrangements until a procurement exercise could be conducted to implement a new service. It was proposed to extend current services by up to six months until 30 September 2017 or until a new service was in place if sooner.

It was further explained that Salford (as the proposed new lead commissioner) intended to manage the tender process and award a new service within the first three months of this extension (by 1 July 2017). The six month extension would offer some degree of flexibility in the timescales which may be necessary when agreeing the service model, financial investments and ensuring the outcomes of public consultation and impact on protected groups were carefully considered across Greater Manchester.

This continued commitment and proposed new service would align these services with the commissioning cycle of core clinical sexual and reproductive health services across Greater Manchester and the Greater Manchester Chlamydia screening service. It was envisaged all sexual health services could be re-tendered collectively with a new Greater Manchester service offer implemented from 1 April 2019.

RESOLVED

(i) That the extension of the existing contractual arrangement for a maximum period of 6 months to 30 September 2017 from the current contract expiry date of 31 March 2017 be approved.

(ii) That it be noted that the Chief Finance Officer and Executive Director of Governance Resources and Pensions have agreed the extension in compliance with the Council's Procurement Standing Orders.

(iii) That the continued investment of £22,560 per annum (£11,280 for the 6 month maximum period as detailed in (i) above towards the existing Greater Manchester collaborative service offer, be approved. The investment will be financed via the Public Health directorate revenue budget which was within the Integrated Commissioning Fund Section 75 allocation.

(iv) That the continued participation within the new Greater Manchester collaborative service contract which will be commissioned by Salford to the period ending 31 March 2019 at a continued annual investment of £22,560 be approved in principle. The investment will continue to be financed via the Public Health directorate revenue budget which is within the Integrated Commissioning Fund Section 75 allocation. A further report will be presented to the Single Commissioning Board during 2017 in advance of the commencement of the new Greater Manchester service contract.

(v) That it be noted that the continued participation in principle, to the Greater Manchester collaborative arrangements (to 31 March 2019) is approved subject to a further detailed review of commissioning intentions beyond this date.

(vi) That it be noted that participation within a Greater Manchester combined sexual health service offer from 1 April 2019 including the level of associated investment, will be subject to a separate decision by Single Commissioning Board members at a later date.

96. ASHTON IN-HOUSE PHARMACISTS

Consideration was given to a report of the Director of Commissioning, which presented the case for continuing funding of in-house pharmacists in the Ashton neighbourhood, using the Better Care Fund monies.

Board members were informed that in-house pharmacists were introduced in the Ashton Neighbourhood in the 2015/16 financial year funded form the Better Care Fund or the commissioning Improvement Scheme. Five Ashton practices who funded their schemes under the Commissioning Improvement Scheme (CIS) did not have a mechanism for the Clinical Commissioning Group to disburse funds to them as the CIS funding stream was paid to practices in two lump sums, which the practices then used to pay for the in-house pharmacists.

It was explained that it was accepted that in-house pharmacists provided financial savings to practice prescribing as well as reducing the workload on GPs. The medicines management team believes that if these five Ashton practices retained the services of an in-house pharmacist throughout 2016/17 this would be a major contributory factor in making significant savings on the Ashton prescribing budget.

RESOLVED

That the five Ashton practices – Ashton GP Service, Bedford House, HT Practice, Tame Valley and Waterloo – receive funding from the Better Care Fund to cover the costs of in-house pharmacists for 2016/17.

97. URGENT ITEMS

The Chair reported that there were no urgent items for consideration at this meeting.

98. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 6 December 2016 commencing at 2.30 pm at New Century House, Denton.

CHAIR

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Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	6 December 2016
Officer of Single Commissioning Board	Kathy Roe – Director Of Finance – Single Commissioning Team Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance Claire Yarwood – Director Of Finance – Tameside Hospital NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 REVENUE MONITORING STATEMENT AT 31 OCTOBER 2016 AND PROJECTED OUTTURN TO 31 MARCH 2017**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the revenue financial position of the Economy. The report provides a 2016/2017 financial year update on the month 7 financial position (at 31 October 2016) and the projected outturn (at 31 March 2017). The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG and the Council are also required to comply with their constituent organisations' statutory functions. A summary of the Tameside Hospital NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.
Recommendations:	Single Commissioning Board Members are recommended: To note the 2016/2017 financial year update on the month 7 financial position (at 31 October 2016) and the projected outturn (at 31 March 2017). Acknowledge the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget. Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report provides the financial position statement of the 2016/17 Care Together Economy for the period ending 31 October 2016 (Month 7 – 2016/17) together with a projection to 31 March 2017 for each of the three partner organisations. The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy.

	Each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017. It should be noted that additional non recurrent budget has been allocated by the Council to Adult Services (£8 million) and Childrens' Services (£4 million) in 2016/17 to support the transition towards the delivery of a balanced budget within these services during the current financial year. It should also be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the existing Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.
Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations it is important that each of the constituent decision making bodies are sighted on the position.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.

Risk Management: These are detailed on slide 10 of the presentation.

Access to Information : Background papers relating to this report can be inspected by contacting :

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TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position: M7

2016/17 Revenue & Capital Monitoring Statements at 31 October 2017 and projected outturn to 31 March 2017

6 December 2016

Stephen Wilde
Tracey Simpson
Ann Bracegirdle

NHS Tameside and Glossop Clinical Commissioning Group

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside Metropolitan Borough

Section 1 - Care Together Economy Revenue Financial Position

Care Together Economy Revenue Financial Position

Organisation	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Tameside & Glossop CCG	218,502	219,686	(1,184)	378,403	381,591	(3,188)	(4,193)	1,005
Tameside MBC	38,939	40,718	(1,779)	69,272	72,322	(3,050)	(2,402)	(648)
Total Single Commissioner	**257,441**	**260,404**	**(2,963)**	**447,675**	**453,913**	**(6,238)**	**(6,595)**	**357**
ICO Deficit	(10,152)	(10,230)	(78)	(17,300)	(17,300)	0	-	-
Total Whole Economy			**(3,041)**			**(6,238)**	**(6,595)**	**357**

The overall financial position of the Care Together Economy has improved by £357k month on month reducing the projected year end deficit to £6.2m or 1.4% of the full year budget. Key points to note are as follows:

Key Risks in Year End Forecast

•That the CCG QIPP doesn't deliver to current planned levels

•That the current level of Delayed Transfers of Care adversely impacts on the delivery of the Winter Plan with associated financial consequences

Planned Mitigations to Identified Risks

•Ownership of individual QIPP schemes together with rigorous monitoring will ensure delivery

•The Winter Plan reflects an integrated approach across the economy which is essential in managing delayed transfers of care (DTOCs) with implementation of the Home First transformation project critical to managing the level of DTOCs.

The CCG figure quoted in table 1 differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP and timing of the recovery plan. This is to ensure consistency of reporting across the Integrated Commissioning Fund, for both CCG and Local Authority. This is presentational only and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit until the savings have been achieved (ie, reported as green in QIPP/recovery plans)

Original commissioner financial gap £21.5m. Still need to close £6.2m of this gap which is dependent on a proportion of amber and red schemes delivering in accordance with the optimism bias applied.

Mitigations to adverse variances contained in Year to Date Position

•Continued work to deliver improvement on the CCG QIPP position following submission of recovery plan.

•Continued work to deliver and identify further savings as part of the TMBC QIPP.

•Diligent efforts in striving to deliver the savings target in full. Significant risk attached to this.

Tameside & Glossop CCG

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	116,043	115,319	724	198,163	198,183	(20)	(48)	28
Mental Health	16,928	16,964	(36)	29,076	29,174	(97)	(74)	(23)
Primary Care	47,897	48,385	(488)	81,655	81,903	(249)	(273)	24
Continuing Care	6,396	6,588	(192)	12,249	12,625	(376)	(269)	(107)
Community	16,017	15,964	53	27,539	27,492	47	(35)	82
Other	12,672	13,773	(1,102)	24,560	24,491	69	(12)	81
QIPP					3,188	(3,188)	(4,193)	1,005
CCG Running Costs	2,549	2,693	(144)	5,162	4,535	627	711	(84)
CCG Total	**218,502**	**219,686**	**(1,184)**	**378,403**	**381,591**	**(3,188)**	**(4,193)**	**1,005**

Overall there has been an improvement to the CCG's projected year end financial position by just over £1m or a 24% reduction in the projected year end variance. It is important to note that the majority of this improvement is a result of non-recurrent means and includes:

- Green rated QIPP schemes have increased by £1,005k to £10,312k
- Other changes in outturn position by directorate:
  - **Acute**: Detailed breakdown of movements in acute providers detailed separately
  - **Primary Care**: Delegated budgets continue to perform to plan.
  - **Community Services**: Slippage relating to 165 Telehealth units (£39k) Correction of double count relating to McMillan GP lead (£35k)
  - **Continuing Care**: Increase in forecast to account for overall economy pressure relating to FNC rate increase £220k. Detailed work on value of 16/17 forecast and monitoring arrangements ongoing.
  - **Other:** QIPP findings as above.
  - **Running Costs**: Value of underspend has decreased (£84k) due to additional VAT costs, regarding the Air conditioning at New Century House.

- Significant improvement in the CCG QIPP position following submission of recovery plan
- Still work to do to ensure delivery of full recurrent savings target.
- CCG current planning to:
  - Deliver 1% surplus in 2016/17 but this is still a significant risk pending progress on the recovery plan
  - Keep 1% of allocation uncommitted
  - Maintain Mental Health parity of esteem
  - Remain within running cost allocation

Recommendations

- Note the updated M7 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position
- Acknowledge significant savings required to close the long term financial gap

The CCG figure quoted in table 1 differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP and timing of the recovery plan. This is to ensure consistency of reporting across the Integrated Commissioning Fund, for both CCG and Local Authority. This is presentational only and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit until the savings have been achieved (ie, reported as green in QIPP/recovery plans)

Tameside MBC

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Adult Social Care & Early Intervention	24,290	25,076	(786)	41,995	43,342	(1,347)	(1,498)	151
Childrens Services, Strategy & Early Intervention	14,906	15,829	(923)	25,877	27,459	(1,582)	(783)	(799)
Public Health	(258)	(187)	(71)	1,400	1,521	(121)	(121)	-
TMBC Total	**38,939**	**40,718**	**(1,779)**	**69,272**	**72,322**	**(3,050)**	**(2,402)**	(648)

Overall the TMBC position has worsened by £648k month on month increasing the projected year end variance to just over £3m, 4.4% on the current years net budget. An explanation of the movements and other background is provided below:

Children's Social Care

•Additional temporary social workers recruited to address caseload capacity (£0.5m), additional external residential and foster care placements (£0.1m), planned savings initiatives yet to be realised (£0.9m), additional minor variations (£0.1m).

Public Health

•Temporary resourcing of the Active Tameside capital investment prudential borrowing repayments is currently under consideration. The temporary resourcing arrangements will be replaced in future years via the recurrent savings achieved from a significant reduction to the annual management fee payable. Currently a borrowing repayment of £0.186m is included within the projected outturn estimate. This is partial offset by underspends elsewhere within Public Health.

Adult Social Care

•Changes to the regulations associated with the Better Care Fund has created a pressure of £1.12m

•CCTV - The service has a projected deficit of £0.100m. A service review is underway in this area to reduce expenditure where appropriate. Updates will be provided in future reports.

•Forecast net expenditure associated with Residential care has reduced since the previous period.

Recommendations

- Note the updated M7 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position

Tameside & Glossop Integrated Care NHS Foundation Trust (ICO)

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Income	118,667	120,354	1,687	202,785	204,904	2,119	204,904	-
Expenditure	123,343	125,575	(2,232)	210,707	212,826	(2,119)	212,826	-
Earnings before interest, taxes, depreciation and amortisation	(4,676)	(5,221)	(545)	(7,922)	(7,922)	-	(7,922)	-
Net Deficit after Exceptional Costs	**(10,152)**	**(10,230)**	**(78)**	**(17,300)**	**(17,300)**	**-**	**(17,300)**	**-**

Financial Position

•For the 7 months to October 2016, the ICO is delivering a deficit of £10.2m, broadly on line with plan.

•The year end forecast is for the planned £17.3m deficit, and assumes the following;

- Delivery of the £7.8m Efficiency savings target
- Delivery of the Tameside and Glossop CCG contract
- Small over performance on all associate PbR contracts
- Financial and performance criteria for receipt of £6.5m Sustainability and Transformation funding (STF) is achieved.
- £17.3m working capital/loan is received to fund the deficit position.
- Agency expenditure does not increase significantly

Key Risks to the Financial Position

•Under-performance of savings target – c.£2.8m of schemes are currently rag rated medium or high risk.

•Increased expenditure on agency staffing.

•Additional unplanned expenditure due to winter pressures.

•Savings relating to transformation schemes delayed.

•Performance targets requiring unplanned expenditure to use the independent sector.

CCG – Provider Performance

Acute Provider Drilldown

•**Tameside FT**: Showing as breakeven by year end due to the expectation that transformational schemes will be realised. The below areas are underspent YTD, however, these underspends should be considered in line with the budget profiling discussed under 'Acute TFT Movement'.

- **Elective:** Colorectal at £43k / Upper Gastro Surgery at £37k
- **Non Elective:** General Medicine at £275k / Gen Surgery at £236k
- **OP Procedures**: Pain Management at £41k / Urology at £21k / Breast at £39k

•**Central Manchester**: Adverse movement of full year forecast due to Critical Care (£121k) / Excess Bed Days (£25k) / Acute Kidney Unit (£30k). Pressure due to macular activity (£305k) continues.

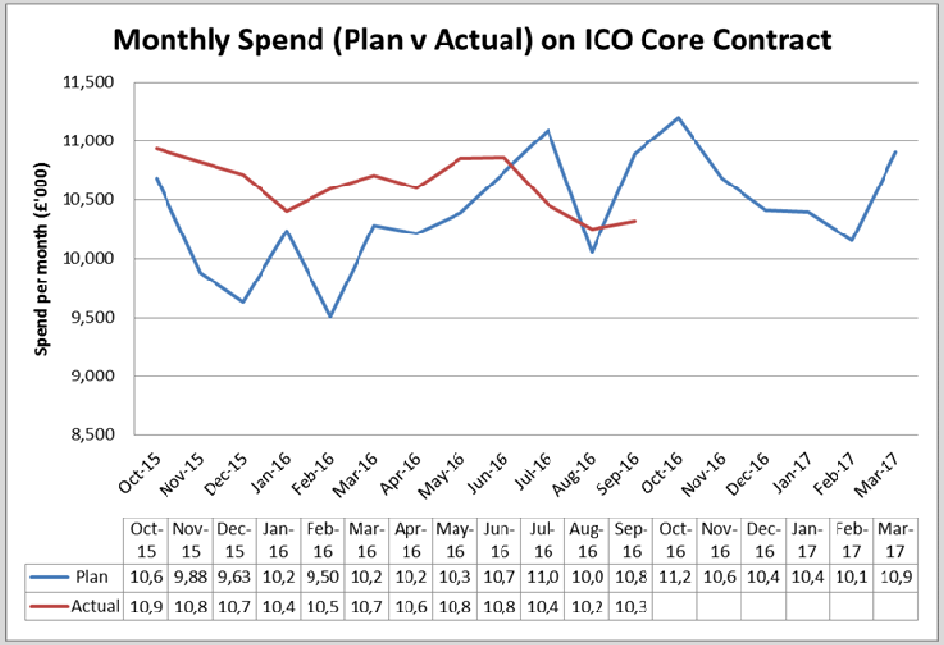
•**Stockport :** Favourable movement of full year forecast due to recognising under performance within Stroke at £165k / Elective T&O at £187k.

	Year to Date			Forecast		
Provider	**Budget**	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
TFT	74,610	74,181	429	127,075	127,075	()
CMFT	13,103	13,648	(545)	22,280	22,926	(646)
SFT	6,968	6,441	527	11,969	11,186	783
UHSM	3,772	3,963	(191)	6,568	6,835	(267)
PAHT	2,356	2,203	153	4,029	3,792	236
SRFT	1,885	2,006	(121)	3,226	3,483	(257)
WWL	813	744	69	1,409	1,320	89
BOLT	47	48	(1)	80	88	(8)
Total	**103,553**	**103,234**	**319**	**176,635**	**176,706**	**(71)**

Acute TFT Movement

•The YTD position is underspent by £429k, of which £280k is non-recurrent and relates to cross year excess bed days

•The below graph shows a spike in the profiling of the budget during July and Sept, resulting in less budget allocation over the winter period of 16-17. As such, it is expected that the current underspent position will come back in line with plan over subsequent months.



Risks

•**Prescribing:** The forecast remains unchanged this month but there is a potential risk to the position pending future price rises. Further investigation is ongoing to clarify the impact of this increase and whether this will be offset by the benefits of QIPP programmes.

Closing the Financial Gap

Establishing the Financial Gap

•Current financial gap across the health and social care economy in Tameside & Glossop will be £70.2m by 20/21

•In 16/17 the gap is £45.7m. This is made of £13.5m CCG, £8m council and £24.2m ICO. The provider gap represents the underlying recurrent financial position at THFT. However, the Trust is in receipt of £6.9m sustainability funding in 2016/17 resulting in a planned deficit of £17.3m

T&G Projected Financial Gap	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000
Tameside MBC	8,000	22,114	22,601	21,752	25,837
Tameside & Glossop CCG	13,500	22,485	22,083	22,209	18,547
Tameside FT (after CIP)	24,200	24,380	24,686	25,049	25,786
Economy Wide Gap	**45,700**	**68,979**	**69,370**	**69,010**	**70,170**

Closing the Financial Gap - CCG

•CCG recovery plan submitted to NHS England which demonstrates initiatives which would allow the CCG to close the £13.5m 16/17 gap and deliver required surplus.

Summary of QIPP	2016/17				2017/18			
£'000s	R	A	G	Total	R	A	G	Total
PRIORITY 1 - Prescribing		1,449	0	**1,449**		1,393		**1,393**
PRIORITY 2 - Effective use of resources/Prior Approval		500		**500**		1,500		**1,500**
PRIORITY 3 - Demand Management	96	265		**361**	828	658		**1,486**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	144	519	**663**		571	523	**1,094**
PRIORITY 5 - Back Office Functions and Enabling Schemes	250			**250**	500	1,000		**1,500**
PRIORITY 6 - Governance		30		**30**		100		**100**
Other Schemes in progress/achieved:	R	A	G	Total	R	A	G	Total
Neighbourhoods			460	**460**		451	230	**681**
Primary Care			1,036	**1,036**		100	1,000	**1,100**
Mental Health			232	**232**	1,000		232	**1,232**
Acute Services - Elective		310	500	**810**	200	1,030	29	**1,259**
Enabling Schemes to facilitate QIPP				**0**		1,000	240	**1,240**
Technical Finance & Reserves		444	4,531	**4,975**				**0**
Other efficiencies		612	3,034	**3,646**			28	**28**
Grand Total	**346**	**3,754**	**10,312**	**14,412**	**2,528**	**7,803**	**2,282**	**12,613**
Including adjustments for Optimum bias	35	1,877	10,312	**12,224**	253	3,902	2,282	**6,436**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								

•Still £3.188k of savings to find in, which reduces to £1,276 if we apply optimism bias rules to out amber/red rated schemes.

•The savings identified are shown in the table to the right with a split between recurrent and non recurrent elements of the savings.

Recurrent vs Non Recurrent	2016/17	2017/18
Recurrent Savings	**4,659**	**11,045**
Red	250	1,700
Amber	2,698	7,803
Green	1,711	1,542
Non Recurrent Savings	**9,753**	**1,568**
Red	96	828
Amber	1,056	0
Green	8,601	740
Total	**14,412**	**12,613**

Closing the Financial Gap - TMBC

Service	Savings Area	Detail	2016/17 R	2016/17 A	2016/17 G	2016/17 Total
Public Health	Savings found	Planned Reduction to annual management fee payable to Active Tameside and other incidental savings			217	217
		Reduction in Community Services contract value - agreed with ICO			169	169
	Additional resource (projected cost pressures)				49	49
	Reduction in estimated capital financing repayments (Active Tameside)	Reduction in capital financing costs in 2016/17 due to rephasing of works to reconfigure Active Tameside estate			456	456
	Savings still to be found			490		490
	sub total Public Health		**-**	**490**	**891**	**1,381**
Adult Social Care	Additional resource (projected cost pressures)				3,908	3,908
	Savings still to be found	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.	997			997
	sub total Adult Social Care		**997**	**-**	**3,908**	**4,905**
Childrens Social Care	Savings found	Reduction to inflationary increases that were projected to materialise during 2016/17.			120	120
	Additional resource (projected cost pressures				1,215	1,215
	Savings still to be found	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.	379			379
	sub total Childrens Social Care		**379**	**-**	**1,335**	**1,714**
TOTAL			**1,376**	**490**	**6,134**	**8,000**
Including adjustment for Optimism Bias			138	245	6,134	**6,517**
	10% of red rated schemes will be realised					
	50% of red rated schemes will be realised					
	100% of red rated schemes will be realised					
QIPP Target						**8,000**
Savings still to be found after accounting for optimism bias						**1,483**

Commissioner Financial Risk within the ICF

- Main financial risks within ICF are listed to the right
- Detailed registers which include further information about the risk and mitigating actions are reviewed by Audit Committee. Copies are available on request.
- Overall level of risk is comparable to that reported at M5.
- Significant risks include:
  - CCG's ability to maintain spend within allocation and deliver a surplus in 16/17: The financial recovery plan submitted to NHS England is being constantly updated to demonstrate how we meet business rules but there is still potentially £2m which may require repayment in 17/18. We now need to focus on the successful delivery of this plan with minimal requirement for loaned funds.
  - Meeting the financial gap recurrently: Many of the actions within the 16/17 recovery plan are non recurrent and transactional in nature. To ensure economy wide gap in met in the long term we need to replace these short term measures with recurrent, activity backed transformational schemes.

Extracts From the Corporate Risk Registers	Probability	Impact	Risk	RAG
The achievement of meeting the Financial Gap recurrently.	4	4	16	R
Over Performance of Acute Contract	3	4	12	A
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	3	4	12	A
Over spend against Continuing Health Care budgets	2	3	6	A
Operational risk between joint working.	1	5	5	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	4	4	16	R
In year cuts to Council Grant Funding	2	3	6	A
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	3	4	12	A
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Provider Market Failure	2	5	10	A
Funded Nursing Care – impact of national changes to contribution rates	4	2	8	A

Other Significant Issues

Tameside Better Care Fund

•Tameside Better Care Fund plan for 16/17 was approved by NHS England on 1 September 2016.

•Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.

•All spend is monitored through the Integrated Care Fund and is being spent in the following areas:

Scheme name	2016-17 budgets (£000's) CCG	TMBC	Total
Urgent Integrated Care Service	**578**	**2,374**	**2,952**
IRIS	578	1,338	1,916
Early Supported Discharge Team		286	286
Community Occupational Therapists		750	1,974
Localities	**412**	**3,265**	**3,677**
Telecare/Telehealth	174	667	841
ICES (Joint Loan Store)	238	450	688
Reablement Services		2,148	2,148
Carers Support (in line with National Conditions of Care act related funding)	**412**	**-**	**412**
Carer Breaks (Adults)	412	-	412
Primary Care (£5 per head for over 75's)	**1,070**	**-**	**1,070**
Existing Grant - Disabled Facilities Grant	**-**	**1,978**	**1,978**
Impact of New Care Act Duties	**-**	**529**	**529**
Integration Pump Primimg	**982**	**-**	**982**
Maintaining Services	**-**	**4,801**	**4,801**
Mental health Services		2,450	2,450
Adult Social Care - Community based Services (Inc care Homes)		2,351	2,351
Contingency	**900**	**-**	**900**
Total	4,354	12,947	17,301
	Funded by (£000's)		
NHS Tameside & Glossop CCG			15,323
Central Funded Grants			1,978
Total BCF Fund			17,301

Derbyshire Better Care Fund

•Derbyshire Better Care Fund for 16/17 has also been approved by NHS England.

•Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.

Scheme name	Hosted by CCG	DCC/Other CCGs	Total
	£000's		
Community Home & Hospital Enhanced care team	**-**	**23,138**	**23,138**
Reablement Services / Community services		18,287	18,287
CDM & Discharge Ward		2,877	2,877
Mental Health		1,974	1,974
Primary Care	**164**	**1,529**	**1,693**
Intergration Pump priming		**8,051**	**8,051**
Maintaining Services	**284**	**24,801**	**25,085**
Maintaining Eligibilty Criteria			-
LCCTS	284		284
Adult Social care		24,801	24,801
Demographic pressures			-
Total	448	57,519	57,967
	Funded by (£000's)		
NHS Tameside & Glossop CCG			2,212
Other CCGs and Central			55,755
Total BCF Fund			57,967

Other Significant Issues

Funded Nursing Care

•40% increase in health contribution toward FNC cases has been agreed nationally. The assessment of the impact to the whole economy has been completed and the additional cost is estimated to be £189k.

•This is an interim change until December 2016 pending the outcome of a national review into FNC charges. There is an element of the rate for agency nursing staff (which could lead to a reduction of the rate in the future regional variation)

Transformation Funding

•Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding is in the process of being developed. It is anticipated that the Investment Agreement will be signed in early December 2016.

Integrated Commissioning Fund 2016/17

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	116,043	115,319	724	198,163	198,183	(20)	(48)	28
Mental Health	16,928	16,964	(36)	29,076	29,174	(97)	(74)	(23)
Primary Care	47,897	48,385	(488)	81,655	81,903	(249)	(273)	24
Continuing Care	6,396	6,588	(192)	12,249	12,625	(376)	(269)	(107)
Community	16,017	15,964	53	27,539	27,492	47	(35)	82
Other	12,672	13,773	(1,102)	24,560	24,491	69	(12)	81
QIPP	0	0		-	3,188	(3,188)	(4,193)	1,005
CCG Running Costs	2,549	2,693	(144)	5,162	4,535	627	711	(84)
CCG sub-total	**218,502**	**219,686**	**(1,184)**	**378,403**	**381,591**	**(3,188)**	**(4,193)**	**1,005**
Adult Social Care & Early Intervention	24,290	25,076	(786)	41,995	43,342	(1,347)	(1,498)	151
Childrens Services, Strategy & Early Intervention	14,906	15,829	(923)	25,877	27,459	(1,582)	(783)	(799)
Public Health	(258)	(187)	(71)	1,400	1,521	(121)	(121)	-
TMBC sub-total	**38,939**	**40,718**	**(1,779)**	**69,272**	**72,322**	**(3,050)**	**(2,402)**	**(648)**
Grand Total	**257,441**	**260,404**	**(2,963)**	**447,675**	**453,913**	**(6,238)**	**(6,595)**	**357**
A: Section 75 Services	**133,491**	**134,725**	**(1,234)**	**232,295**	**234,984**	**(2,688)**		
CCG	109,871	110,026	(155)	190,275	191,113	(838)		
TMBC	23,620	24,699	(1,079)	42,020	43,870	(1,850)		
B: Aligned Services	**105,674**	**107,198**	**(1,524)**	**183,729**	**186,829**	**(3,099)**		
CCG	90,355	91,179	(824)	156,477	158,377	(1,899)		
TMBC	15,319	16,019	(700)	27,252	28,452	(1,200)		
C: In Collaboration Services	**18,276**	**18,481**	**(205)**	**31,650**	**32,101**	**(451)**		
CCG	18,276	18,481	(205)	31,650	32,101	(451)		
TMBC	-	-	-	-		-		

Section 2 - Care Together Economy Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total £'000s	Approved 2016/2017 Allocation £'000s	Expenditure to Month 7 £'000s	Projected Expenditure to 31 March 2017 £'000s	2016/2017 Projected Outturn Variation £'000s	Comments
Childrens Services - In Borough Residential Properties	912	912	615	675	237	Purchase of 2 additional in-borough properties including associated property adaptations. An Edge of Care establishment is yet to be purchased
Public Health - Leisure Estate Reconfiguration	20,268	5,203	2,923	4,064	1,139	Active Dukinfield - The scheme is on budget with an anticipated opening date of 2 January 2017. Active Longendale - The scheme is on budget with an anticipated opening date of 19 November 2016. Active Hyde – Work due to start on site in late January 2017 with completion scheduled for October/November 2017. Denton Wellness Centre – Layout plans and development agreement being established. Facility to be completed late 2018. The programme total of all schemes includes the sum of £ 2.650 million which will be wholly financed by Active Tameside.
Adult Services - Disabled Facilities Grant - Adaptations	1,978	1,978	618	1,978	0	
Total	**23,158**	**8,093**	**4,156**	**6,717**	**1,376**	

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Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	6 December 2016
Reporting Member / Officer of Single Commissioning Board	Angela Hardman, Director of Public Health and Performance
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE**

Report Summary:

This paper provides an update on CCG assurance and performance, based on the latest published data (at the time of preparing the report). The September position is shown for elective care and a November 'snap shot' in time for urgent care.

Also attached to this report is a CCG NHS Constitution scorecard, showing CCG performance across indicators.

The format of this report now includes elements on quality from the Nursing and Quality directorate.

The assurance framework for 2016/17 has been published nationally.

Performance issues remain around waiting times in diagnostics and the A & E performance.

	RTT Incomplete	52WW	Diagnostic	A&E
Standard	**92%**	**0**	**1%**	**95%**
Actual	**92.1%**	**0**	**1.24%**	**87.63%**

The number of our patients still waiting for planned treatment 18 weeks and over continues to decrease and the risk to delivery of the complete standard and zero 52 week waits is being reduced.

Cancer standards were achieved in September. Quarter 2 performance achieved apart from 62 day consultant upgrade.

Endoscopy is no longer a challenge in diagnostics at Central Manchester.

A&E Standards were failed at Tameside Hospital Foundation Trust.

Financial Year to 13 Nov 2016	87.63%
April 2016/17	92.46%
May 2016/17	92.16%
June 2016/17	86.61%
July 2016/17	84.98%
August 2016/17	90.48%
September 2016/17	82.78%
October 2016/17	84.10%
November to 13 2016/17	88.03%

Recommendations:	Note the 2016/17 CCG Assurance position. Note performance and identify any areas they would like to scrutinise further.
Financial Implications **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However, it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particualry around budgets will be key to ensuring aggregate financial balance.
Legal Implications: (Authorised by the Borough Solicitor)	It is critical to raising standards whilst meeting budgetary requirements that we develop a clear outcome framework that is properly monitored and meets the statutory obligations and regulatory framework of all constituent parts. This doesn't currently achieve this but is work in progress. On 28 October 2016, the Greater Manchester Health and Social Care Strategic Partnership Board approved an Assurance Framework, including Performance Dashboard (**Appendix 1**), and we now need to ensure that we are in a position to replicate this in addition to any additional local records.
How do proposals align with Health & Wellbeing Strategy:	Should provide check and balance assurances as to whether meeting strategy.
How do proposals align with Locality Plan:	Should provide check and balance and assurances as to whether meeting plan.
How do the proposals align with the Commissioning Strategy	Should provide check and balance and assurances as to whether meeting strategy.
Recommendations / views of the Professional Reference Working Group:	This section is not applicable as this report is not received by the Professional Reference Group.
Public and patient implications:	The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help to understand the imkpact we are making to reduce health inequalities.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in the report.

What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management :	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2016/17.
Access to Information :	The background papers relating to this report can be inspected by contacting Ali Rehman by:: Telephone: 0161 366 3207 e-mail: alirehman@nhs.net

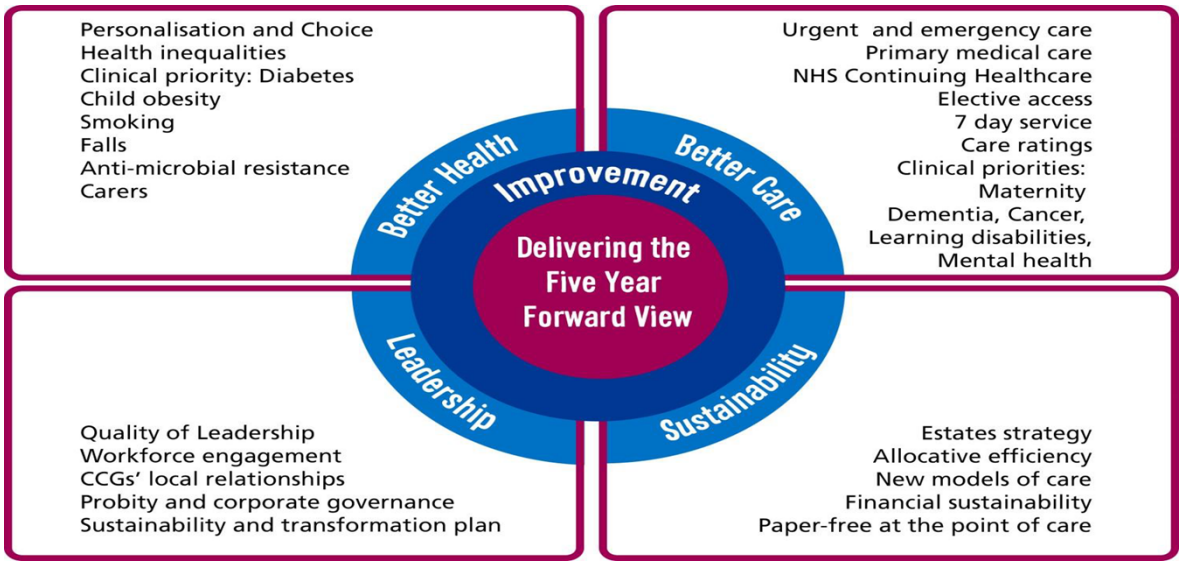
1. INTRODUCTION

1.1 This paper provides an update on CCG assurance and performance, based on the latest published data (at the time of preparing the report). The September position is shown for elective care and a November "snap shot" in time for urgent care. It includes a focus on current waiting time issues for the CCG.

1.2 It should be noted that providers can refresh their data in accordance with national guidelines and this may result in changes to the historic data in this report.

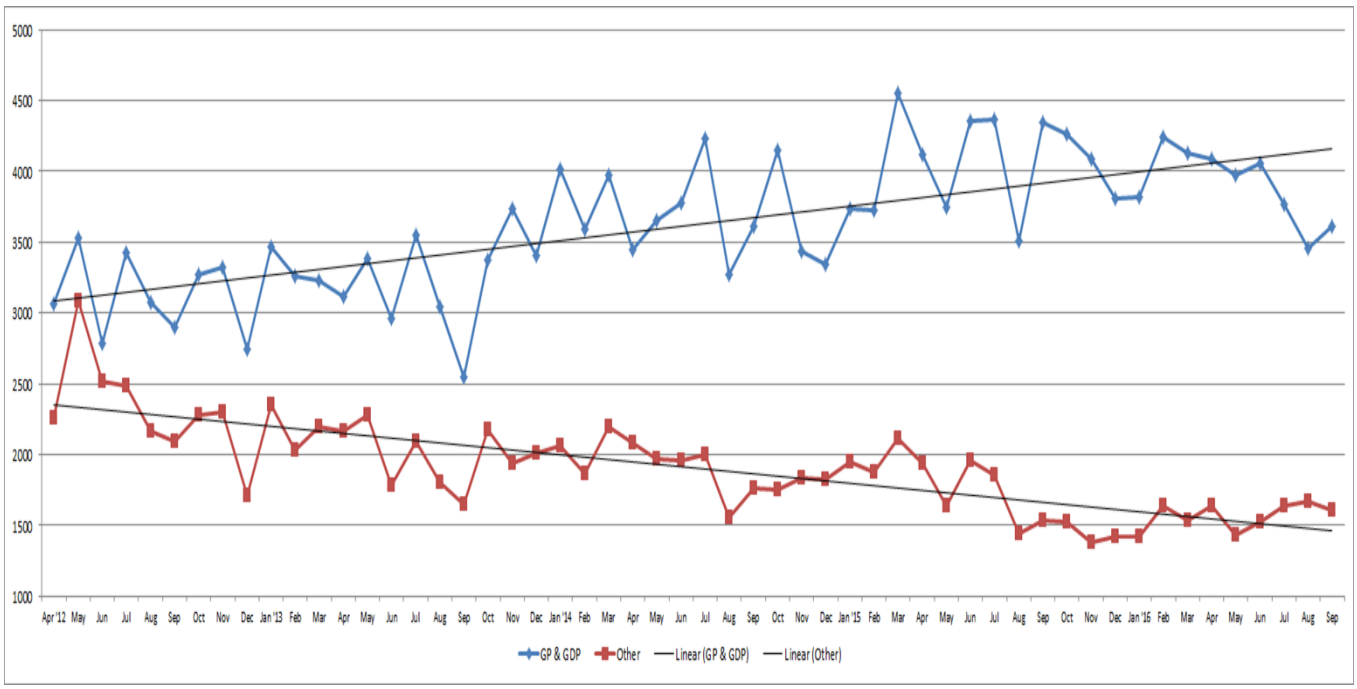
2. CCG ASSURANCE

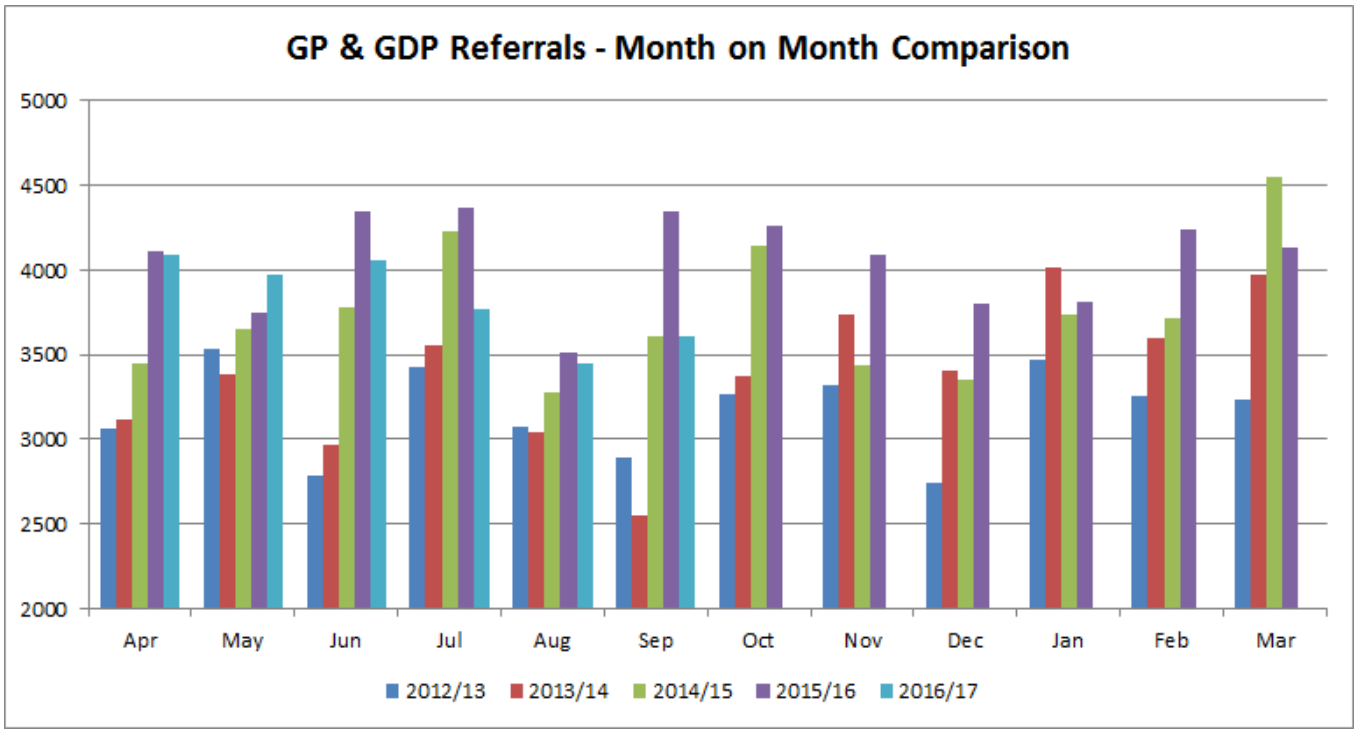
2.1 The assurance framework for 2016/17 has been published nationally however, we are awaiting the framework from GM Devolution. A recent WebEx led by NHS England provided further info on the new assessment framework for 2016/17. CCGs will be assessed in relation to four key areas of their functions and responsibilities, health, care, sustainability and leadership. The overall rating for 2016/17 and metrics will be transparent and published on My NHS. Six clinical priorities will have independent moderation to agree an annual summative assessment. Below is the framework NHS England intend to use.



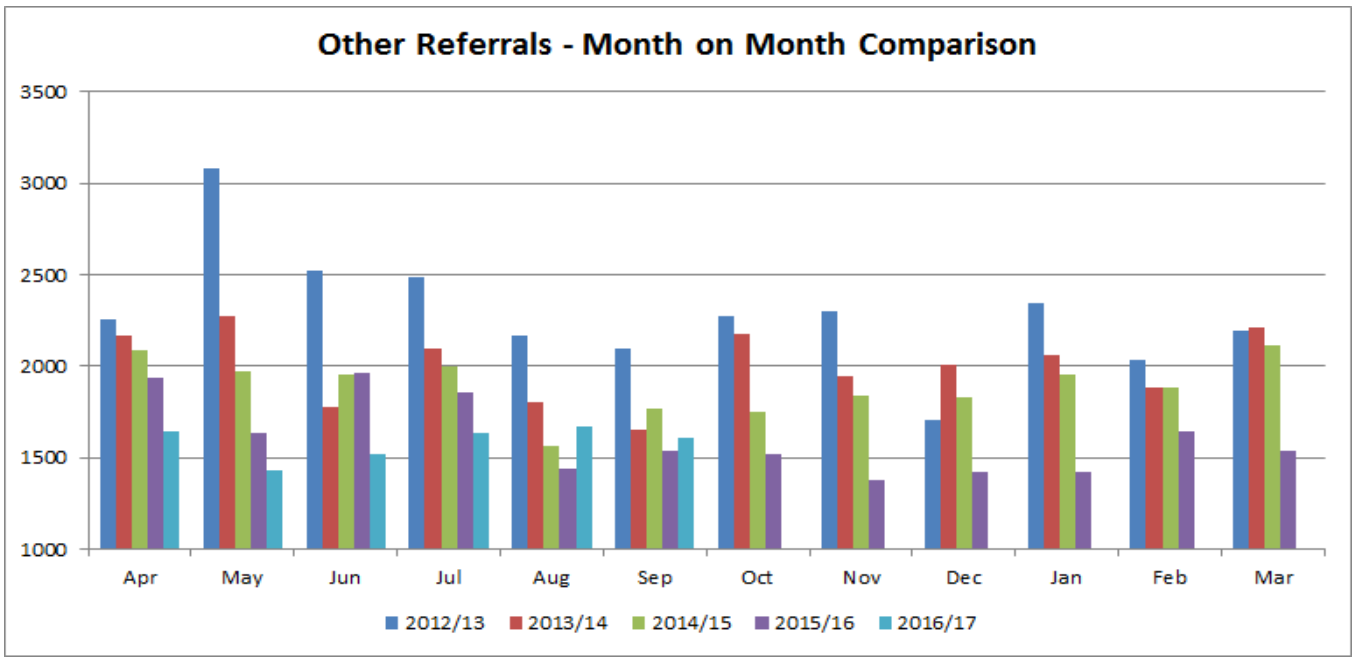
3. CURRENT CCG PERFORMANCE

ReferralsGP/GDP referrals to TFT only have decreased during the month of September compared to the same period last year, however referrals have been on upward trend. Referral data is analysed at practice and specialty level and shared with practices.



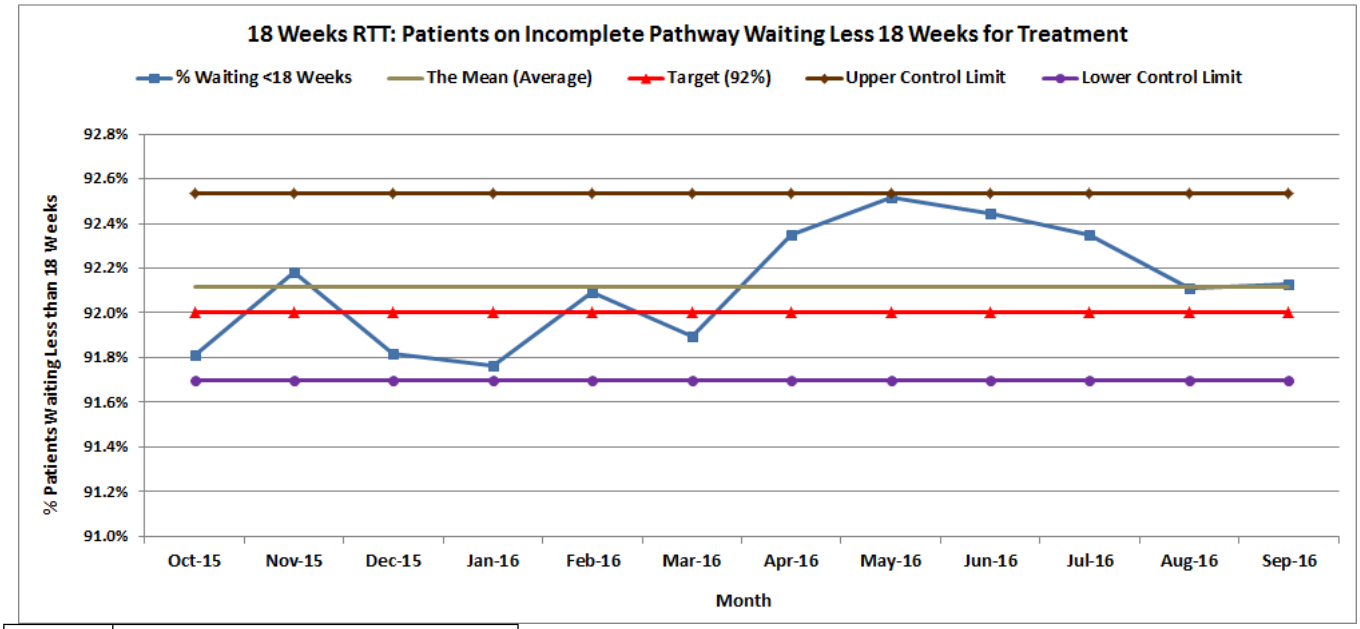


3.2 Other referrals (TFT only) have increased during the month of September compared to the same period last year. The general trend has been decreasing.



Elective Care – please note the September position is the latest available data

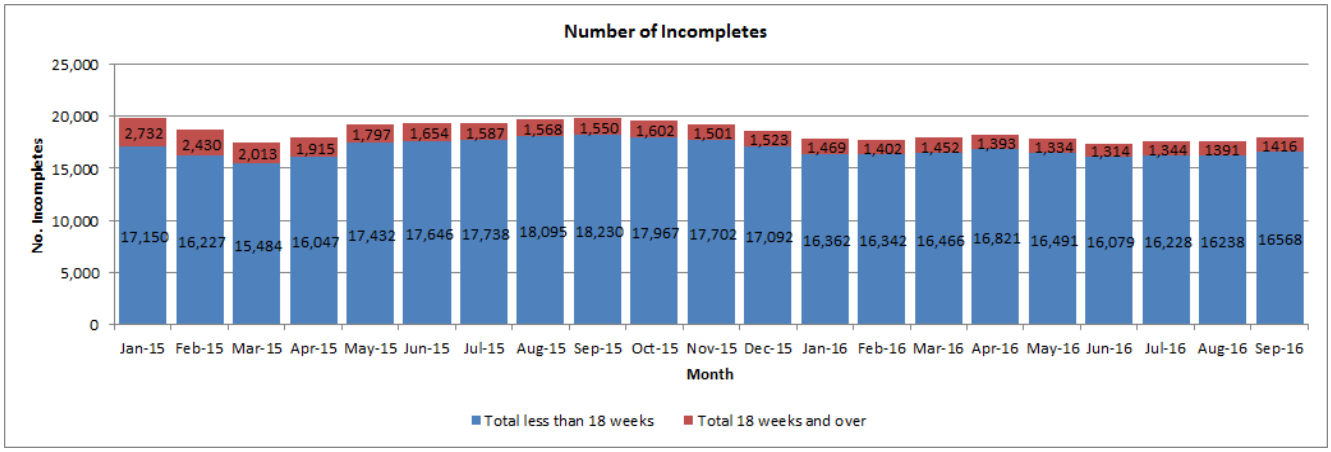
3.3 In September the CCG achieved the incompletes standard at 92.35% and THFT continued to achieve at 93.06%. The National RTT stress test demonstrates the trust are continuing to reduce the risk of failing RTT, this will have a positive impact on CCG performance.



	Incomplete (Standard 92%)	
	CCG Actual	**THFT Actual**
Apr	89.34%	87.50%
May	90.65%	89.30%
Jun	91.44%	90.70%
Jul	91.79%	91.30%
Aug	92.03%	92.10%
Sep	92.16%	92.22%
Oct	91.81%	92.2%
Nov	92.18%	92.8%

Dec	91.8%	92.2%
Jan	91.8%	92.7%
Feb	92.1%	92.4%
Mar	91.9%	92.5%
Apr	92.4%	92.9%
May	92.5%	92.9%
June	92.4%	93.0%
July	92.3%	93.0%
Aug	92.1%	93.0%
Sept	92.1%	93.0%

3.4 The total number of incompletes for the CCG has stabilised and slightly increased this is primarily due to the increase in under 18 weeks. The over 18 weeks has increased slightly. There has been an increase in over 40 week waiters and the 28 to 40 waits have increased.



	T&G Patients at all Providers																				
Weeks Wait	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
52+ Weeks	29	18	6	6	5	1	1	0	1	2	0	1	0	2	0	1	0	0	1	1	0
40+ Weeks (inc. 52+	149	118	90	126	101	92	61	45	39	30	28	42	47	51	49	34	31	24	28	35	44
28-40 Weeks	680	642	512	525	486	422	307	300	307	272	295	341	339	255	245	265	274	251	243	274	276
18-27 Weeks	1903	1670	1411	1264	1210	1140	1219	1223	1204	1300	1178	1140	1083	1096	1158	1094	1029	1039	1073	1082	1096
14-17 Weeks	2395	1959	1884	1254	1828	1987	1890	2039	2242	2288	2038	2051	2191	1930	1836	1424	1670	1591	1415	1546	1697
0-13 Weeks	14755	14268	13600	14793	15604	15659	15848	16056	15988	15679	15664	15041	14171	14412	14630	15397	14821	14488	14813	14692	14871
Total	19882	18657	17497	17962	19229	19300	19325	19663	19780	19569	19203	18615	17831	17744	17918	18214	17825	17393	17572	17629	17984

3.5 There were no patients waiting more than 52 weeks for treatment.

3.6 Tameside expects to report zero 52-week waits for September. However the risk of 52 week waiters remains with ten patients at 43 to 47 weeks. Also there are 47 patients waiting over 36 weeks without a decision to admit. Earlier this year the University Hospitals of South Manchester FT identified a data quality issue of patients who had been waiting >52 weeks not being identified. UHSM, NHSE, Monitor, and SMCCG have been addressing this matter. Following identification of this issue earlier this year, intensive validation work was carried out at the Trust and are still finding new >52 week pathways. As of 28 October 2016, eight patients had been waiting longer than 52 weeks when treated. Zero patients still waiting to be treated. These were patients that we were not aware of when the last report was provided. We are being updated regularly on the position and are keeping a close eye on the issue.

	# of Patients Waiting by Specialty									% of Incomplete at 28 Weeks
	0-18 Weeks	18-22 Weeks	23-27 Weeks	28-32 Weeks	33-37 Weeks	38-42 Weeks	43-47 Weeks	48-51 Weeks	52+ Weeks	
Cardiology	1037	56	38	11	7	4	0	0	1	2.0%
Cardiothoracic Surgery	48	6	4	4	2	1	0	0	0	10.8%
Dermatology	1015	16	4	2	2	0	0	0	0	0.4%
Ear, Nose & Throat (ENT)	1330	45	21	16	2	2	0	0	0	1.4%
Gastroenterology	664	24	11	3	0	1	0	0	0	0.6%
General Medicine	990	23	19	10	4	2	0	0	0	1.5%
General Surgery	1873	70	45	15	3	4	1	1	0	1.2%
Geriatric Medicine	13	1	1	0	0	0	0	0	0	0.0%
Gynaecology	1224	55	33	19	6	2	0	1	0	2.1%
Neurology	5	0	0	0	0	0	0	0	0	0.0%
Neurosurgery	18	3	1	0	0	0	0	0	0	0.0%
Ophthalmology	1172	22	1	4	2	1	1	0	0	0.7%
Oral Surgery	4	1	1	0	0	0	0	0	0	0.0%
Other	2677	119	63	31	13	10	4	0	0	2.0%
Plastic Surgery	175	10	4	8	1	1	1	0	0	5.5%
Rheumatology	261	6	4	3	2	2	0	0	0	2.5%
Thoracic Medicine	178	15	7	4	1	1	0	0	0	2.9%
Trauma & Orthopaedics	2542	130	82	38	16	9	2	0	0	2.3%
Urology	1012	107	34	15	9	3	1	0	0	2.4%
Total	**16,238**	**709**	**373**	**183**	**70**	**43**	**10**	**2**	**1**	**1.8%**

3.7 The specialities of concern with regard to current performance or Clearance Rate (how long to treat the total waiting list assuming no more were added and the number completed each week stays the same) are shown on the right. Clearance Rate is used as an indicator of future performance with 10 to 12 weeks usually being seen as the maximum to deliver performance however with specialities with low numbers this is less accurate. The clearance rates have recently improved.

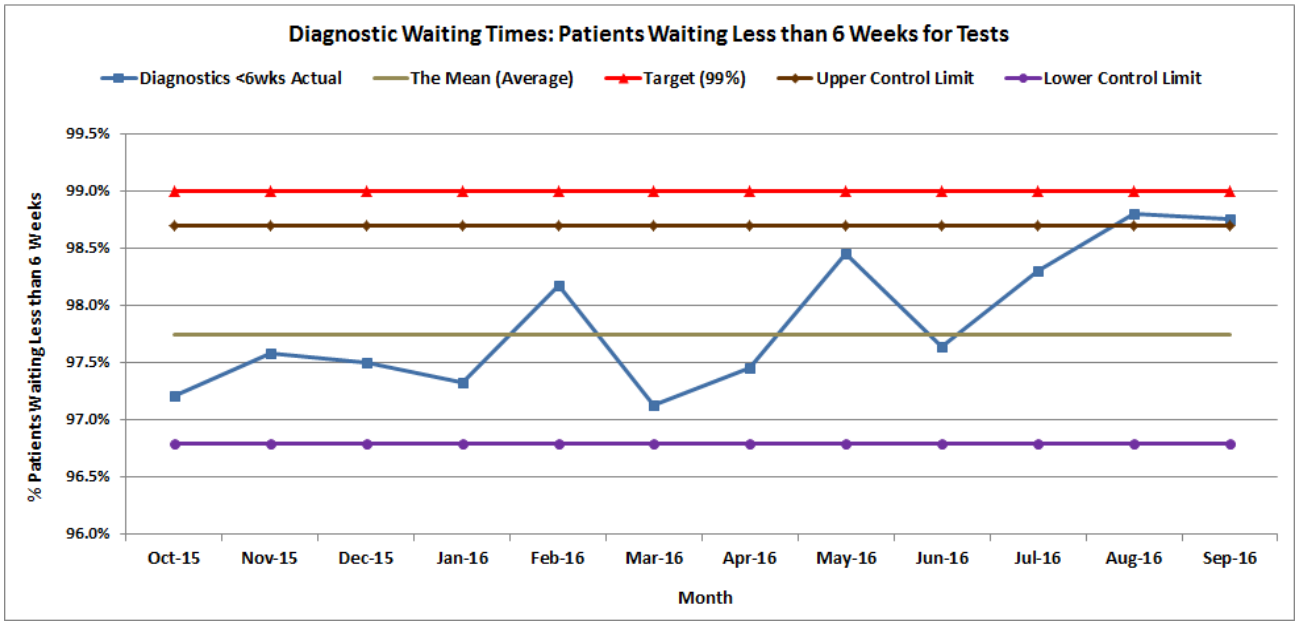
% of Patients waiting less than 18 weeks, by speciality, from All	Incomplete	Clearance Rates	
	Threshold 92%	Threshold 10-12 weeks	Change from last month
Cardiology	89.72%	16.49	⇧
Cardiothoracic Surgery	92.98%	11.40	⇧
Dermatology	95.56%	14.64	⇩
Ear, Nose & Throat (ENT)	94.14%	12.83	⇩
Gastroenterology	93.32%	9.71	⇧
General Medicine	92.38%	13.67	⇩
General Surgery	93.92%	8.77	⇧
Geriatric Medicine	84.62%	13.00	⇧
Gynaecology	92.90%	11.65	⇧
Neurology	100.00%	8.00	
Neurosurgery	88.89%	6.55	⇧
Ophthalmology	97.34%	8.87	⇩
Plastic Surgery	85.78%	11.83	⇧
Rheumatology	93.20%	9.80	⇩
Thoracic Medicine	83.67%	11.36	⇩
Trauma & Orthopaedics	90.69%	14.24	⇧
Urology	86.59%	10.82	⇩
Other	91.17%	11.57	⇩
Total	**92.13%**	11.66	⇧

3.8 One of these are the specialities where THFT also failed the standard and still have a backlog. Whilst clearing the backlog for Gynaecology and Urology, Orthopaedics has reduced. Overall the backlog at THFT has decreased by 47.

Specialty	Incomplete Performance	> 18 Weeks	< 18 Weeks	Total	September Backlog	August Backlog	July Backlog	June Backlog	May Backlog	April Backlog	March Backlog	February Backlog	January Backlog	December Backlog	November Backlog	October Backlog	September Backlog	August Backlog
General Surgery	94.22%	132	2151	2283												10	40	70
Urology	92.89%	45	588	633		15		9	7	7	30	30	40	20	5	25	10	
Orthopaedics	87.62%	236	1670	1906	84	92	100	100	100	89	120	130	140	160	150	180	210	210
ENT	93.47%	64	916	980														
Ophthalmology	99.40%	3	500	503														
Oral Surgery	92.01%	43	495	538			2											
Neurosurgery	93.75%	1	15	16		1			2	1								
Plastic Surgery	94.00%	3	47	50		2		2	1						7	30	15	
Adult Medicine	92.15%	71	834	905														
Gastroenterology	93.12%	51	690	741										6	30			
Cardiology	92.04%	82	948	1030										6		10	40	40
Dermatology	96.00%	43	1032	1075						9								
Rheumatology	94.24%	11	180	191														
Gynaecology	92.20%	86	1016	1102		21	40	44	50	70	60	25						
Other	95.94%	61	1441	1502														
Trust	**93.07%**	**932**	**12523**	**13455**	84	131	142	155	160	176	210	190	180	192	**193**	**255**	**315**	**320**

Diagnostics- please note the September position is reported in this update

3.9 In September we failed the diagnostic standard at 1.24% against 1.0% Standard for waiting 6 or more weeks. This was primarily due to Tameside Trust. This month we have seen a further decrease in over 6 week waiters at Care UK and Pioneer Healthcare.



Financial Year 2016 - 2017 **Reporting Month** September **Choose Trust** All

Diagnostic Waiting - All Providers

	All Providers	July 2016				August 2016				September 2016			
		# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks
Endoscopy	THFT	507	0	0	0.0%	527	6	0	1.1%	581	2	2	0.7%
	CMMC	44	1	3	8.3%	50	5	1	10.7%	73	7	0	8.8%
	Pennine Acute	10	4	0	28.6%	8	2	3	38.5%	7	1	1	22.2%
	Salford	2	1	0	33.3%	4	0	0	0.0%	2	0	0	0.0%
	South Mc.	5	0	0	0.0%	7	0	0	0.0%	5	0	0	0.0%
	Stockport	23	1	0	4.2%	20	0	1	4.8%	20	1	1	9.1%
	Ashton Primary Care Centre	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Care UK	11	0	0	0.0%	8	0	0	0.0%	13	0	0	0.0%
	Other	4	1	0	20.0%	3	0	0	0.0%	3	0	0	0.0%
	Total	606	8	3	1.8%	627	13	5	2.8%	704	11	4	2.1%
Non-Endoscopy	THFT	2677	31	0	1.1%	2475	18	5	0.9%	2354	24	2	1.1%
	CMMC	313	4	4	2.5%	339	2	3	1.5%	378	4	3	1.8%
	Pennine Acute	73	0	0	0.0%	44	0	0	0.0%	62	0	0	0.0%
	Salford	149	0	0	0.0%	157	0	0	0.0%	169	1	0	0.6%
	South Mc.	58	1	0	1.7%	88	0	0	0.0%	88	0	0	0.0%
	Stockport	171	0	0	0.0%	170	0	0	0.0%	183	0	0	0.0%
	Ashton Primary Care Centre	32	0	0	0.0%	13	0	0	0.0%	38	0	0	0.0%
	Care UK	524	24	0	4.4%	601	8	0	1.3%	591	9	0	1.5%
	Other	68	6	0	8.1%	89	1	1	2.2%	39	0	0	0.0%
	Total	4065	66	4	1.7%	3976	29	9	0.9%	3902	38	5	1.1%
	Overall Position	**4671**	**74**	**7**	**1.70%**	**4603**	**42**	**14**	**1.20%**	**4606**	**49**	**9**	**1.24%**

3.10 This means we failed every month last year and continue to fail this year, but there has been an increase in performance in April and May. June's performance deteriorated due to Care UK. July's and August performance has increased. There has been a slight decrease in performance in September.

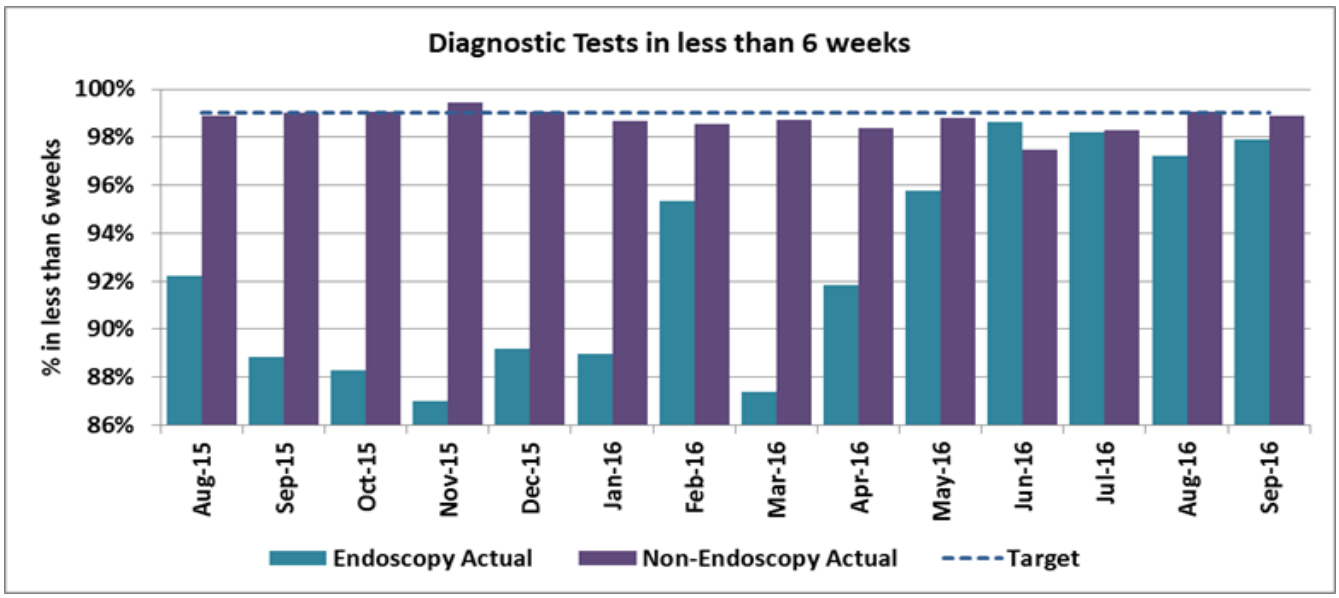
3.11 At the end of September 58 patients were waiting 6 weeks and over for a diagnostic test, 9 of which were over 13 weeks. 14 were at Central Manchester Trust.

Provider	Test	Total 6-13 weeks	13+ Weeks
CMMC	**Total**	**11**	**3**
	Cardiology - echocardiography	2	3
	Colonoscopy	4	0
	Flexi sigmoidoscopy	1	0
	Gastroscopy	2	0
	Magnetic Resonance Imaging	2	0
Pennine Acute	**Total**	**1**	**1**
	Colonoscopy	1	0
	Gastroscopy	0	1
Salford	**Total**	**1**	**0**
	Magnetic Resonance Imaging	1	0
Stockport	**Total**	**1**	**1**
	Colonoscopy	1	1
THFT	**Total**	**26**	**4**
	Audiology - Audiology Assessments	17	2
	Colonoscopy	1	2
	Computed Tomography	5	0
	Gastroscopy	1	0
	Neurophysiology - peripheral neurophysiology	2	0
Care UK	**Total**	**9**	**0**
	Audiology - Audiology Assessments	1	0
	Computed Tomography	1	0
	Magnetic Resonance Imaging	7	0
	Total	**49**	**9**

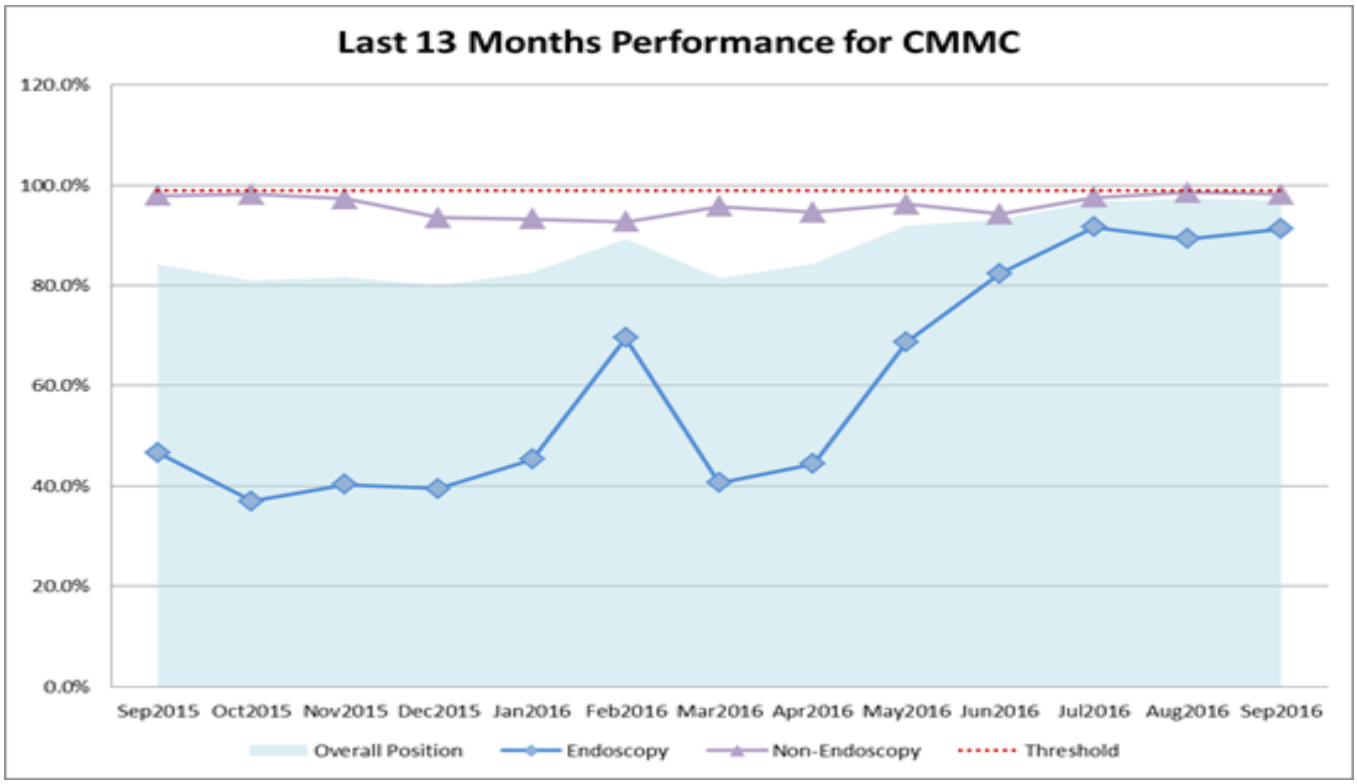
3.12 The backlog in endoscopy appears to have decreased and now accounts for 26% of breaches. Central Manchester Trust has agreed with a private provider to undertake additional activity to help with the backlog clearance.

Diagnostic Waiting - All Tests for All

All Providers		July 2016				August 2016				September 2016			
		# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks
Endoscopy	Colonoscopy	256	5	3	3.0%	270	3	3	2.2%	314	7	3	3.1%
	Cystoscopy	45	0	0	0.0%	51	0	0	0.0%	51	0	0	0.0%
	Flexi sigmoidoscopy	79	0	0	0.0%	75	1	0	1.3%	69	1	0	1.4%
	Gastroscopy	226	3	0	1.3%	231	9	2	4.5%	270	3	1	1.5%
	Total	606	8	3	1.8%	627	13	5	2.8%	704	11	4	2.1%
Non-Endoscopy	Audiology - Audiology Assessments	433	29	0	6.3%	345	18	5	6.3%	253	18	2	7.3%
	Barium Enema	0	0	0	0.0%	0	0	0	0.0%	2	0	0	0.0%
	Cardiology - echocardiography	407	1	3	1.0%	473	0	3	0.6%	519	2	3	1.0%
	Cardiology - electrophysiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Computed Tomography	781	0	0	0.0%	695	3	0	0.4%	703	6	0	0.8%
	DEXA Scan	78	0	0	0.0%	56	0	0	0.0%	77	0	0	0.0%
	Magnetic Resonance Imaging	1146	27	0	2.3%	1226	6	0	0.5%	1265	10	0	0.8%
	Neurophysiology - peripheral neurophysiology	160	7	0	4.2%	169	1	1	1.2%	109	2	0	1.8%
	Non-obstetric ultrasound	1031	2	0	0.2%	986	1	0	0.1%	948	0	0	0.0%
	Respiratory physiology - sleep studies	23	0	0	0.0%	24	0	0	0.0%	19	0	0	0.0%
	Urodynamics - pressures & flows	6	0	1	14.3%	2	0	0	0.0%	7	0	0	0.0%
	Total	4065	66	4	1.7%	3976	29	9	0.9%	3902	38	5	1.1%
	Overall Position	**4671**	**74**	**7**	**1.70%**	**4603**	**42**	**14**	**1.20%**	**4606**	**49**	**9**	**1.24%**

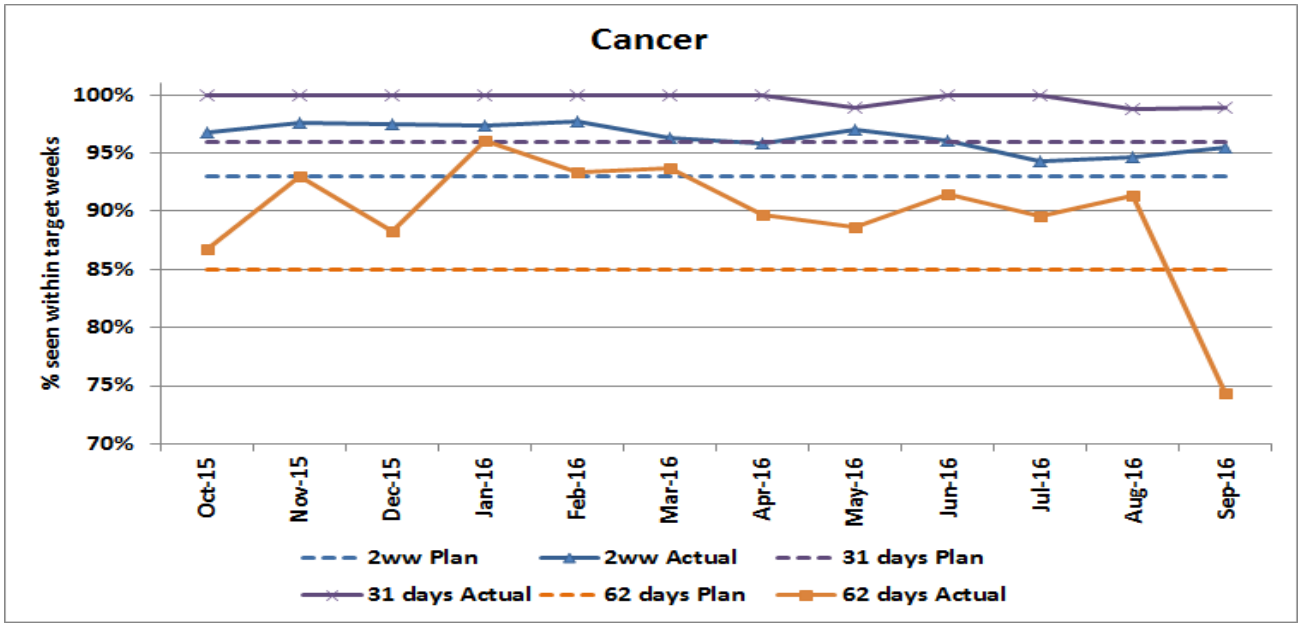


3.13 THFT performance in endoscopy has stayed the same as last month and Central Manchester showing an increase in performance.



Cancer- please note the September position is reported in this update

3.14 We achieved all the standards In September and achieved all standards in Quarter 2 apart from consultant upgrade.



3.15 Our full performance is shown below with all standards achieved. Quarter 2 standards achieved apart from 62 day consultant upgrade.

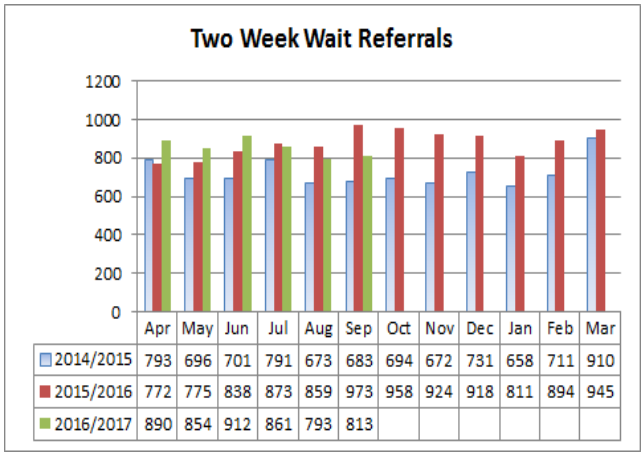
		Performance									No. of patients not receiving care within standard in September
Indicator Name	**Standard**	**March 15/16**	**April 16/17**	**May 16/17**	**June 16/17**	**Q1 16/17**	**July 16/17**	**August 16/17**	**September 16/17**	**Q2 16/17**	
Cancer 2 week waits	93.00%	96.3%	95.82 %	97.07 %	96.12 %	96.34 %	94.32 %	94.64 %	95.43%	94.78 %	33
Cancer 2 week waits - Breast symptoms	93.00%	98.88 %	93.88 %	98.00 %	95.79 %	95.92 %	94.00 %	96.66 %	97.30%	95.85 %	2
Cancer 62 day waits – GP Referral	85.00%	93.75 %	89.66 %	88.64 %	91.49 %	90.00 %	89.58 %	91.30 %	74.36%	86.47 %	10
Cancer 62 day waits - Consultant upgrade	85.00%	88.24 %	83.33 %	86.67 %	94.44 %	88.24 %	82.35 %	100%	53.85%	82.98 %	6
Cancer 62 day waits – Screening	90.00%	100%	100%	100%	60.00 %	87.50 %	100%	100%	100%	100%	0

Cancer day 31 waits	96.00%	100%	100%	98.89 %	100%	99.65 %	100%	98.81 %	98.85%	99.24 %	1
Cancer day 31 waits – Surgery	94.00%	100%	100%	100%	100%	100%	100%	100%	94.44%	97.83 %	1
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0

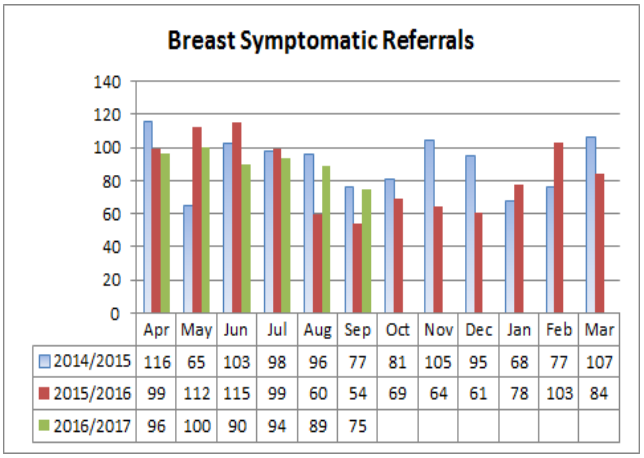
3.16 Tameside achieved all the standards in sept we are awaiting Q2 data.

		Performance									
Indicator Name	**Standard**	**March 15/16**	**April 16/17**	**May 16/17**	**June 16/17**	**Q1 16/17**	**July 16/17**	**August 16/17**	**September 16/17**	**Q2 16/17**	**No. of patients not receiving care within standard in September**
Cancer 2 week waits	93.00%	95.8%	95.8%	97.1%	96.6%	96.5%	94.8%	95.4%	95.4%		37
Cancer 2 week waits - Breast symptoms	93.00%	98.8%	93.8%	98.0%	94.4%	95.5%	94.7%	94.3%	97.3%		2
Cancer 62 day waits – GP Referral	85.00%	95.9%	91.3%	87.7%	91.0%	90.2%	88.2%	92.3%	86.8%		4.5
Cancer 62 day waits - Consultant upgrade	85.00%	87.1%	89.5%	84.6%	93.5%	89.5%	86.1%	100%	79.3%		3.5
Cancer 62 day waits - Screening	90.00%	100%	N/A	N/A	100%	100%	N/A	N/A	N/A		0
Cancer day 31 waits	96.00%	100%	98.6%	100%	100%	99.5%	100%	100%	100%		0
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	100%	100%	100%		0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	N/A	100%	100%	100%	100%	100%		0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	100%	100%	100%		0

3.17 The increase in two week wait referrals continues. Breast however, have recently been close to 2015/16 levels.

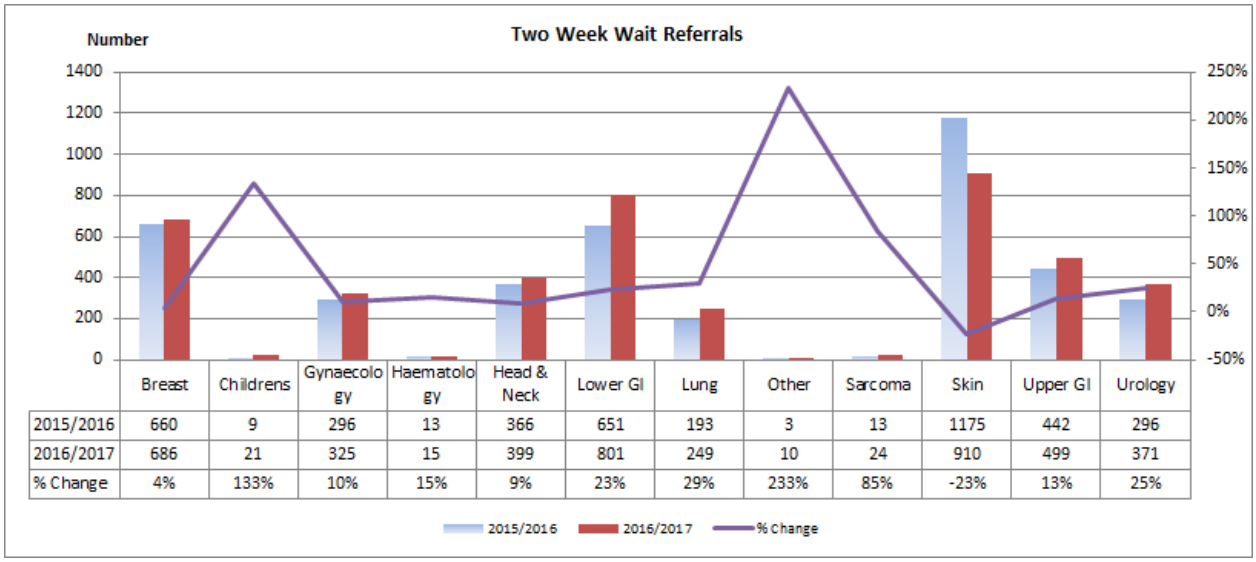


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015	793	696	701	791	673	683	694	672	731	658	711	910
2015/2016	772	775	838	873	859	973	958	924	918	811	894	945
2016/2017	890	854	912	861	793	813						



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015	116	65	103	98	96	77	81	105	95	68	77	107
2015/2016	99	112	115	99	60	54	69	64	61	78	103	84
2016/2017	96	100	90	94	89	75						

3.18 The year to date increases in referrals continues compared to the same period last year with Haematology, Urology, Lower GI, Head and Neck, breast and lung showing the larger increases.



	Breast	Childrens	Gynaecology	Haematology	Head & Neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urology
2015/2016	660	9	296	13	366	651	193	3	13	1175	442	296
2016/2017	686	21	325	15	399	801	249	10	24	910	499	371
% Change	4%	133%	10%	15%	9%	23%	29%	233%	85%	-23%	13%	25%

Urgent Care – please note position reported is at 13th November.

3.19 THFT A&E performance is as below.

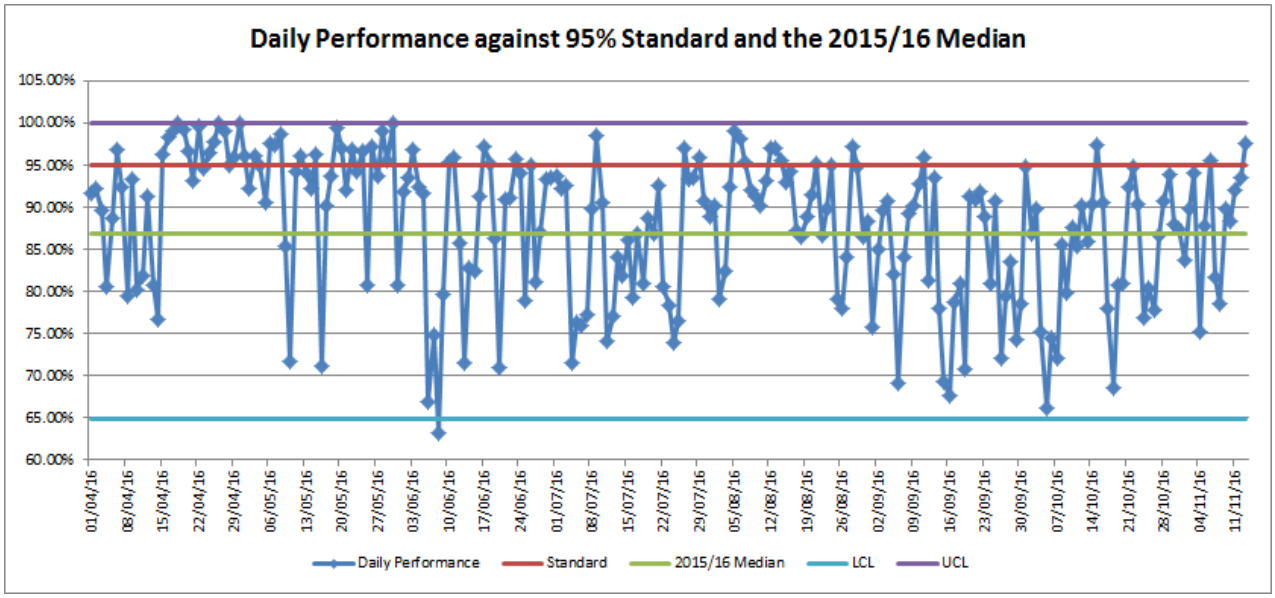
Apr-16	May-16	Jun-16	July-16	Aug-16	Sept-16	Oct-16
92.46%	**92.16%**	**86.61%**	**84.98%**	**90.48%**	**82.74%**	**84.05%**

3.20 We are currently the third best performer across the GM trusts YTD, reported through Utilisation Management. Our June and July, August performance and September performance to the 13th has not achieved the standard.

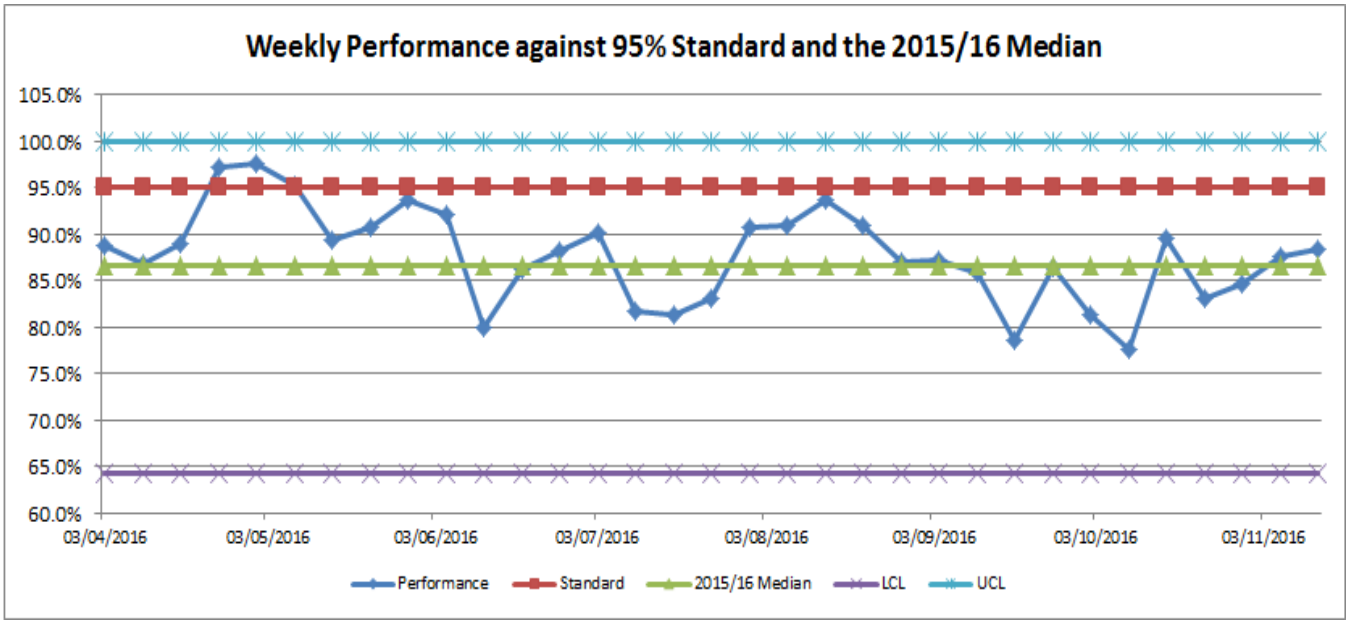
	Financial Year to 13 November 16	April 2016/17	May 2016/17	June 2016/17	July 2016/17	August 2016/17	September 2016/17	October 2016/17	Nov to 13th 2016/17
Wigan	**90.47%**	**92.93%**	**90.30%**	**93.87%**	**89.67%**	**92.04%**	**91.97%**	**84.50%**	**86.85%**
Salford	**89.27%**	**92.52%**	**90.21%**	**94.05%**	**81.69%**	**89.80%**	**91.70%**	**87.27%**	**85.03%**
Tameside	**87.63%**	**92.46%**	**92.16%**	**86.61%**	**84.98%**	**90.48%**	**82.74%**	**84.10%**	**88.03%**

Oldham	85.15%	86.89%	90.39%	86.58%	83.72%	88.64%	84.31%	77.58%	80.75%
Bury	84.19%	82.72%	84.74%	86.35%	82.90%	82.57%	87.58%	83.14%	82.51%
Bolton	83.34%	80.25%	81.29%	85.33%	81.94%	86.13%	87.03%	81.54%	83.78%
Stockport	79.12%	79.31%	81.59%	85.26%	81.51%	77.11%	71.17%	77.62%	79.16%
North Manchester	77.00%	80.20%	77.90%	75.11%	71.24%	83.27%	77.04%	77.30%	71.76%

3.21 Recent performance is on a downward trend. Previous Improvement was being maintained by close monitoring in A&E underpinned by an electronic board. As use of the board becomes embedded it is hoped that senior manager scrutiny can reduce.



3.22 Activity was well managed during the two day period of junior doctors industrial action. Activity levels were not below normal levels and performance was above the standard.

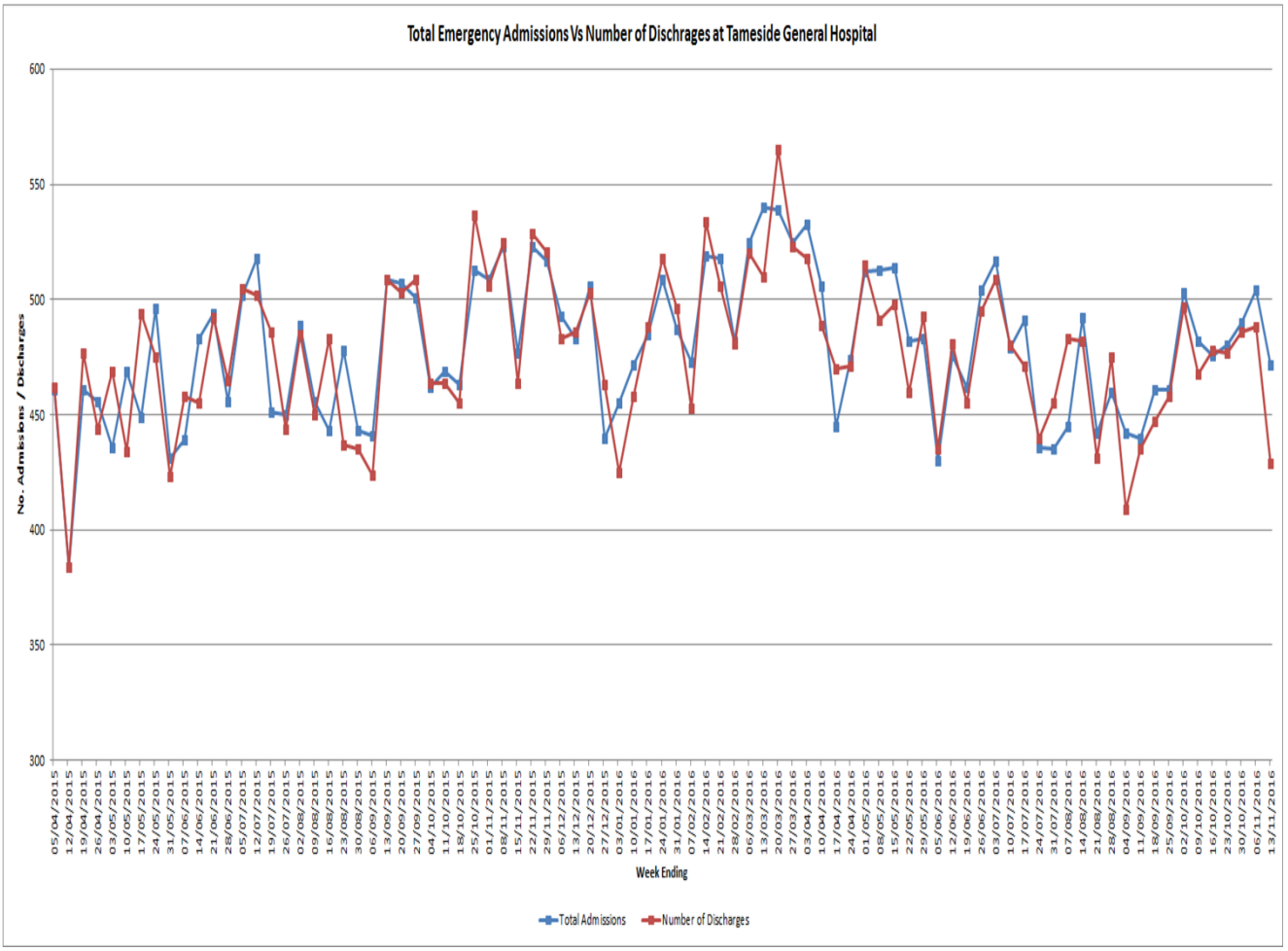


3.23 There has previously been considerable variation on a daily basis with no clear reason, but more recently that has stabilised. During April the standard was achieved but May, June, July, August and September has seen a drop in performance.

3.24 During June, July August and September late first assessment is the main cause of A&E breaches with patients having late assessments as the highest reason for breaches. The patients waiting also impact on cubicle availability which results in breaches due to late first assessments. Previously the main breach reason was awaiting a bed.

Breach Reason (Actual)	w/e 7 Aug	w/e 14 Aug	w/e 21 Aug	w/e 28 Aug	w/e 4 Sep	w/e 11 Sep	w/e 18 Sep	w/e 25 Sep	w/e 2 Oct	w/e 9 Oct	w/e 16-Oct	w/e 23-Oct	w/e 30-Oct	w/e 06-Nov	Cumulative
Awaiting bed	34	15	51	54	72	38	91	70	120	103	56	89	61	59	4216
Specialty Delay	20	18	17	19	14	18	54	13	29	37	15	33	16	14	1327
Delayed Medical Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	1	511
Other	8	2	4	2	5	1	11	8	9	13	37	11	12	6	749
Late First Assessment	61	27	39	85	77	136	174	99	102	191	48	124	124	96	5986
Clinical	9	24	20	20	20	20	17	20	26	25	12	13	27	17	1118
CT Delay	1	4	1	1	1	5	4	4	3	0	2	6	1	2	212
Late Referral to Specialty	0	2	8	13	1	8	10	10	9	11	3	6	7	7	389
Seen after 4 hours	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23
Awaiting transport	4	2	1	3	4	3	3	3	9	4	2	4	1	4	254
Pathology Delay	0	1	0	1	0	2	0	2	0	0	0	2	0	2	70
XR Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21
Unknown	0	0	0	0	0	0	0	0	0	1	0	0	0	0	85
Total	**137**	**95**	**141**	**198**	**194**	**231**	**364**	**229**	**307**	**385**	**175**	**288**	**249**	**208**	**14961**

3.25 We frequently have fewer emergency discharges than emergency admissions and so routinely have to escalate discharge to manage the daily demand. Darnton House has been open a while now and second floor opened 16 beds.


Total Emergency Admissions Vs Number of Dischrages at Tameside General Hospital
No. Admissions / Discharges
600
550
500
450
400
350
300
Week Ending
Total Admissions
Number of Discharges

3.26 Slight increase in A&E attendances during April with much larger increase during May and slight increase in June. July saw a larger increase in attendances compared to 2015/16 and admissions have also increased. This has decreased in August and increased again in September. The number of 4 hour breaches has decreased significantly during April but increased in May June and July. This also decreased in August and increased in September.

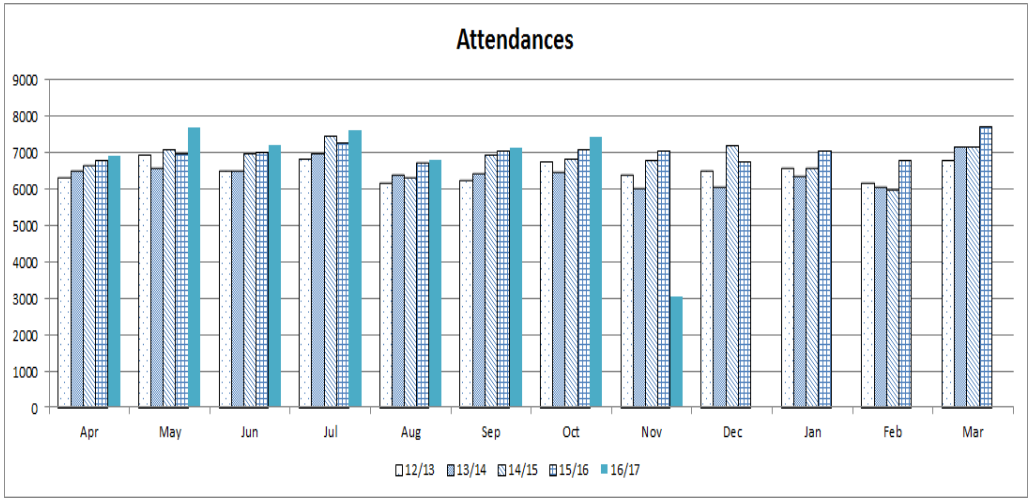
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
A&E Attendances	6892	7680	7182	7608	6799	7109	7394
4 hour Breaches	520	601	967	1143	647	1227	1179
% Seen within 4 hours	92.46%	92.17%	86.54%	84.98%	90.48%	82.74%	84.05%
Admissions via A&E	1761	1883	1767	1775	1767	1705	1777
Other Emergency Admissions	302	305	299	263	267	280	336
All Emergency Admissions	2063	2188	2066	2038	2034	1985	2113
Discharges	2106	2088	2093	2018	2049	1899	1985

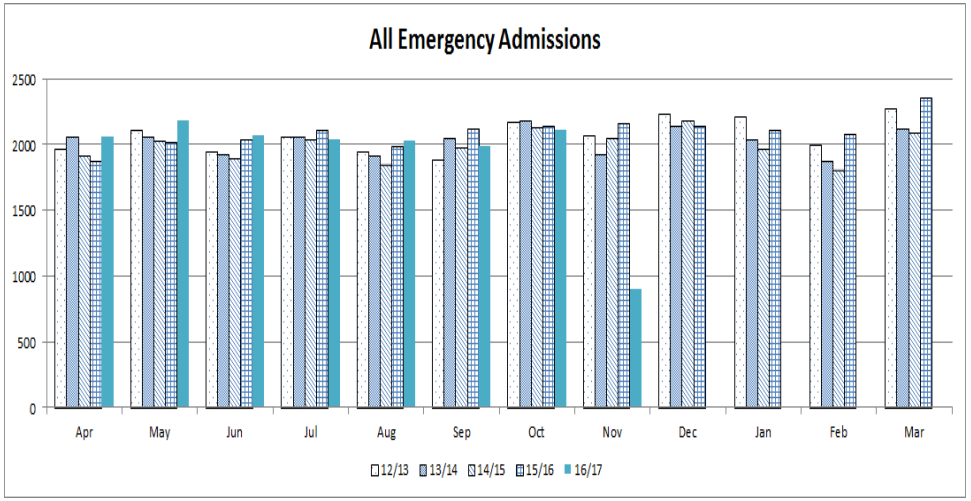
Variance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
A&E Attendances	104	715	155	347	62	72	313
4 hour Breaches	-405	156	503	547	-83	364	-50
Admissions via A&E	171	199	47	-16	86	-59	31
Other Emergency Admissions	9	-34	-23	-62	-40	-86	-60
All Emergency Admissions	180	165	24	-78	46	-145	-29
Discharges	186	80	50	-142	103	-206	-193

% variance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
A&E Attendances	1.5%	10.3%	2.2%	4.8%	0.9%	1.0%	4.4%
4 hour Breaches	-43.8%	35.1%	108.4%	91.8%	-11.4%	42.2%	-4.1%
Admissions via A&E	10.8%	11.8%	2.7%	-0.9%	5.1%	-3.3%	1.8%
Other Emergency Admissions	3.1%	-10.0%	-7.1%	-19.1%	-13.0%	-23.5%	-15.2%
All Emergency Admissions	9.6%	8.2%	1.2%	-3.7%	2.3%	-6.8%	-1.4%
Discharges	9.7%	4.0%	2.4%	-6.6%	5.3%	-9.8%	-8.9%



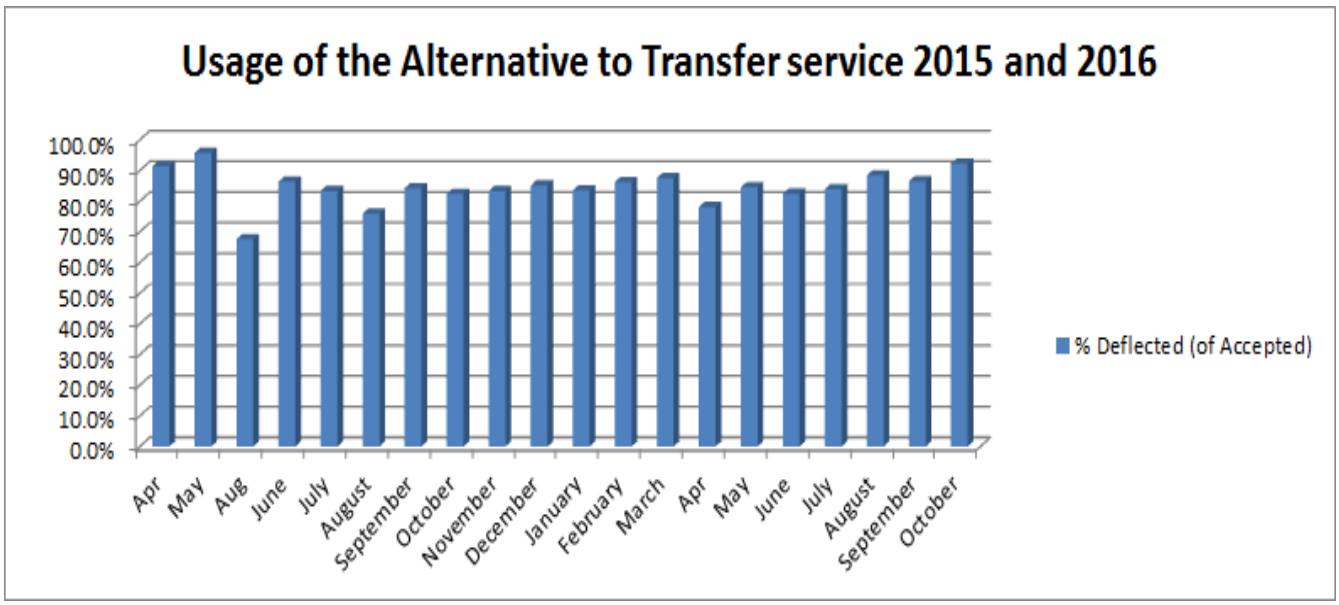


3.27 Since September 2015 there has been considerable variation in the numbers of attendances and admissions and breaches have risen significantly. During April this had stabilised and breaches had reduced, which now look to have increased during May, June, July August and September.

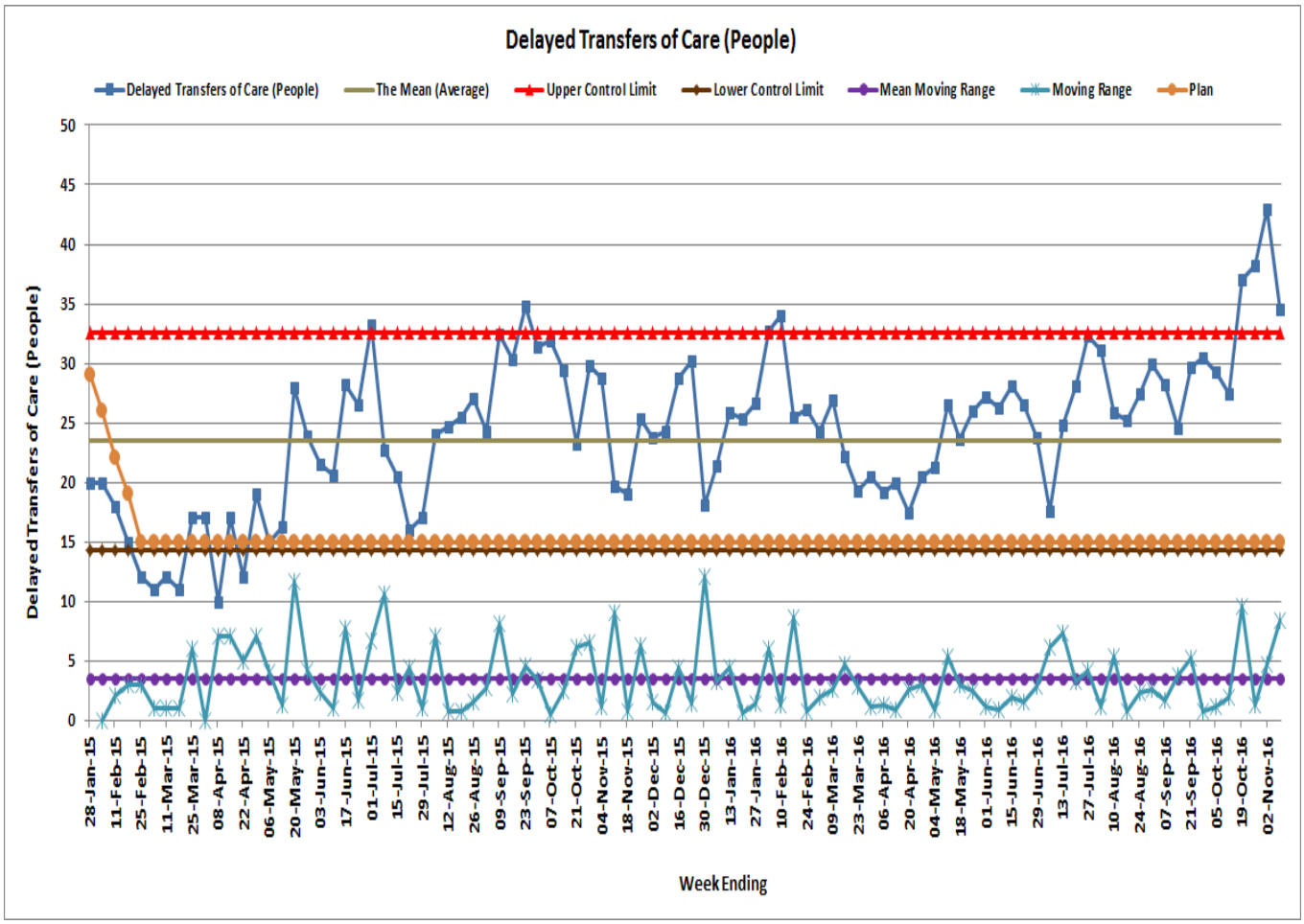
Week Ending	Actual Number of A&E Type 1 Attendances	Actual Number of 4 hour Type 1 breaches	Actual Performance	Number of Emergency Admissions via A&E	Number of Direct Emergency Admissions	Total Emergency Admissions
03 Jul	1686	166	90.2%	443	73	516
10 Jul	1701	310	81.8%	422	59	481
17 Jul	1785	335	81.2%	424	67	491
24 Jul	1752	296	83.1%	378	60	438
31 Jul	1673	154	90.8%	376	60	436
07 Aug	1496	139	90.7%	386	59	445
14 Aug	1491	95	93.6%	419	75	494
21 Aug	1535	141	90.8%	383	60	443
28 Aug	1533	199	87.0%	402	55	457
04 Sep	1637	209	87.2%	398	43	441
11 Sep	1636	233	85.8%	367	64	431
18 Sep	1702	364	78.6%	392	69	461
25 Sep	1691	230	86.4%	409	52	461
02 Oct	1637	307	81.2%	421	81	502
09 Oct	1692	381	77.5%	404	72	476
16 Oct	1658	181	89.1%	398	78	476
23 Oct	1691	290	82.9%	410	70	480
30 Oct	1616	249	84.6%	396	96	492
06 Nov	1681	212	87.4%	418	85	503
13 Nov	1630	190	88.3%	398	74	472

3.28 Usage of the Alternative to Transfer service continues to be good and the level of deflections remains above 80%.

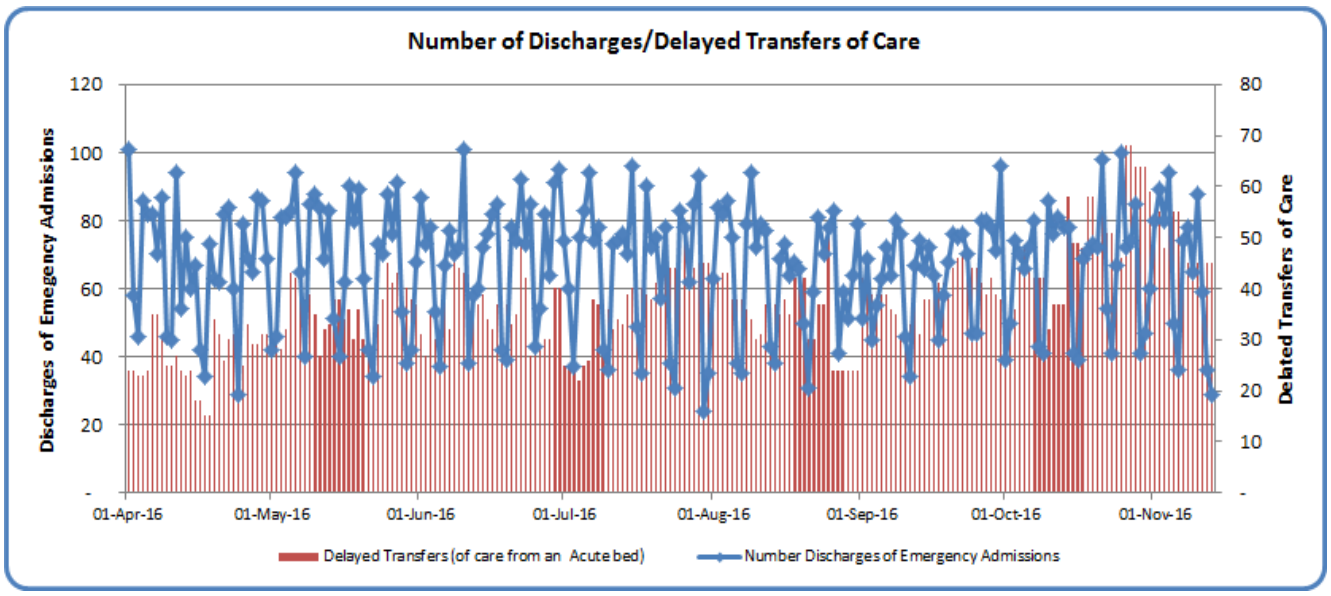
	April	May	June	July	August	September	October	November to 13th
Referrals	198	183	178	221	190	188	214	66
Accepted	196	183	177	220	190	188	213	66
Red Refusals to Hospital also seen	18	15	17	27	34	25	32	6
Deflected	139	142	132	162	138	141	167	55
Accepted %	99.0	100	99.4	99.5	100	100	99.5	100
% Deflected (of Referrals)	78.1	85	82.5	83.9	88.5	86.5	92.3	92
% Deflected (of Accepted)	**78.1**	**85**	**82.5**	**83.9**	**88.5**	**86.5**	**92.3**	**92**

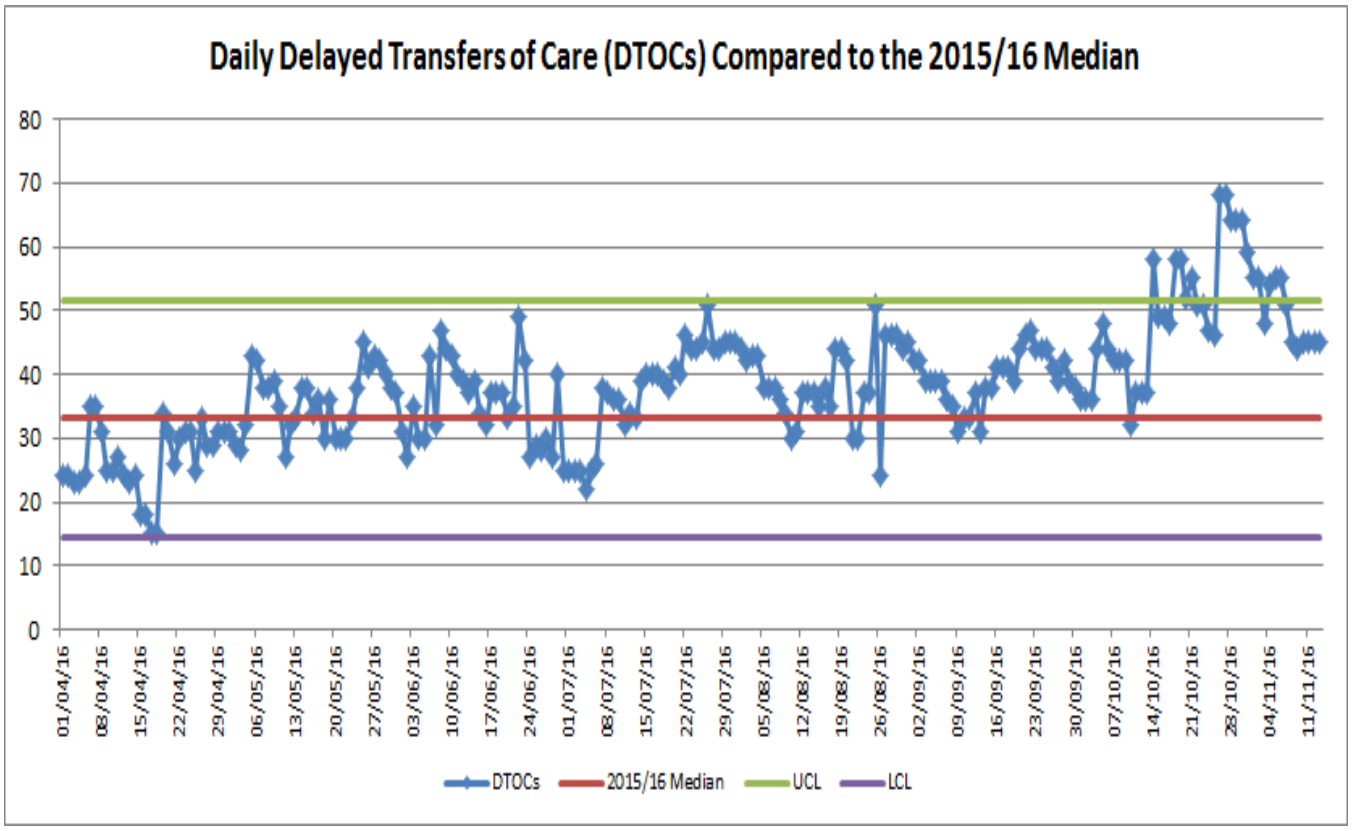


3.29 The number of Delayed Transfers of Care (DTOC) recorded has increased recently.



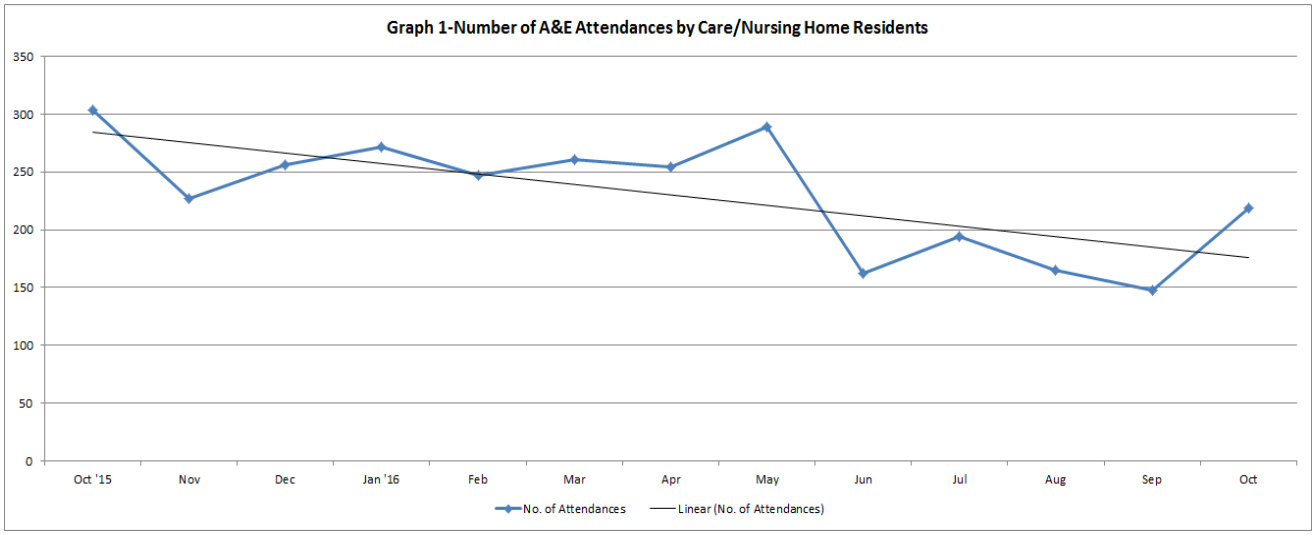
3.30 Reducing DTOC and the level of variation day by day is a key aspect of the improvement plan with Integrated Urgent Care Team designed to significantly impact on bed availability by improving patient flow out of the hospital and avoiding admissions. This should deliver a culture of' Discharge to Assess' which is key to delivering the national expectation that trusts will have no more than 2.5% of bed base occupied by DTOC.


Number of Discharges/Delayed Transfers of Care
Discharges of Emegency Admissions
Delated Transfers of Care
120
100
80
60
40
20
-
80
70
60
50
40
30
20
10
-
01-Apr-16
01-May-16
01-Jun-16
01-Jul-16
01-Aug-16
01-Sep-16
01-Oct-16
01-Nov-16
Delayed Transfers (of care from an Acute bed)
Number Discharges of Emergency Admissions

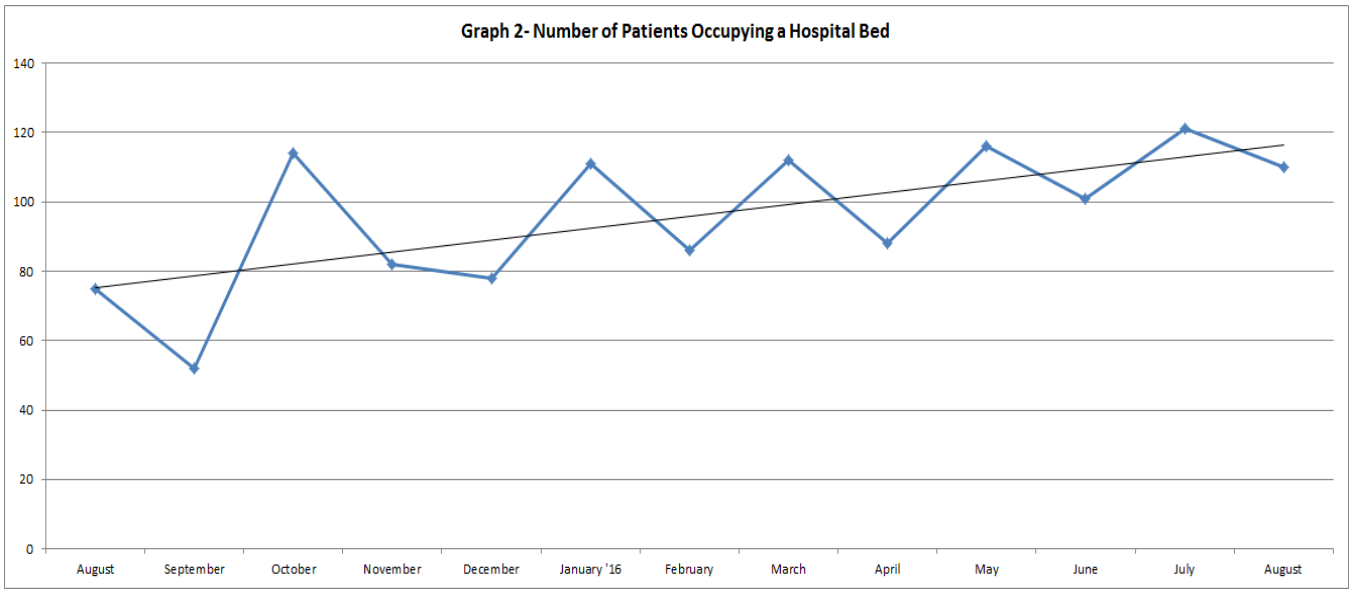

Daily Delayed Transfers of Care (DTOCs) Compared to the 2015/16 Median
80
70
60
50
40
30
20
10
0
01/04/16
08/04/16
15/04/16
22/04/16
29/04/16
06/05/16
13/05/16
20/05/16
27/05/16
03/06/16
10/06/16
17/06/16
24/06/16
01/07/16
08/07/16
15/07/16
22/07/16
29/07/16
05/08/16
12/08/16
19/08/16
26/08/16
02/09/16
09/09/16
16/09/16
23/09/16
30/09/16
07/10/16
14/10/16
21/10/16
28/10/16
04/11/16
11/11/16
DTOCs
2015/16 Median
UCL
LCL

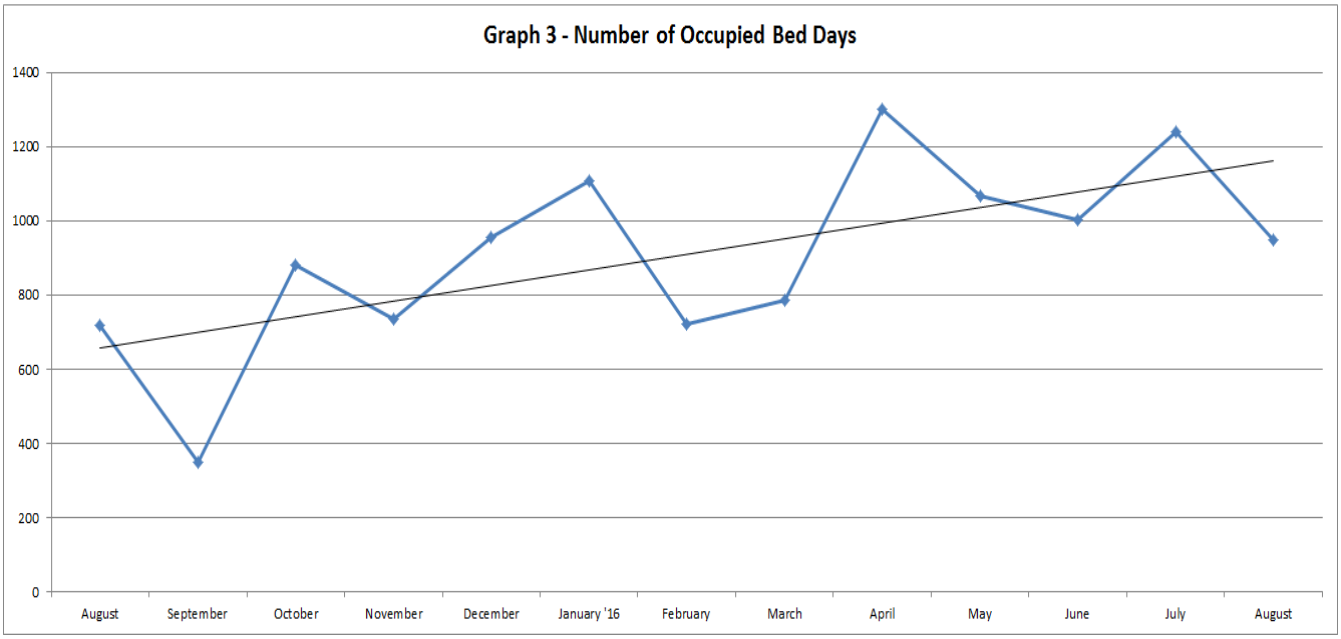
Care Homes

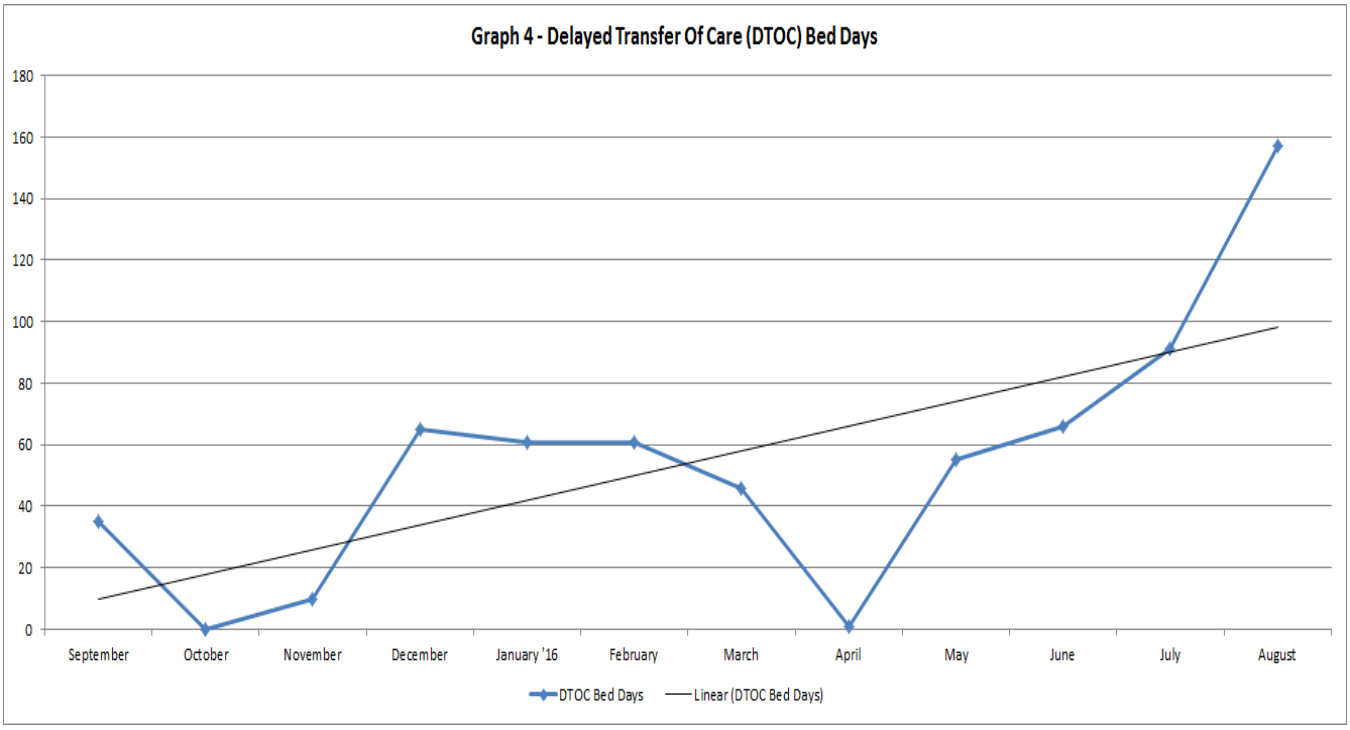
3.31 The decision was made to specifically look at the care homes use of our urgent care systems. This was to allow us to look to see if we can identify themes and trends regarding particular care home providers. In doing this it would allow us to focus support which will be individual to providers. Trying to establish a robust and consistent dataset has been challenging given that we are looking at one specific client group that uses multiple elements of an urgent care system. Data submission remains a challenge, we are working with the relevant urgent care partners to get to a position where we will receive month end live data. The graphs below represent the cumulative activity for the periods detailed above each graph. We would aim to deliver a monthly reporting system that would allow health and social care services to interpret the data to develop appropriate support plans. Some examples of the data collected to date used by the care home steering group are shown below.



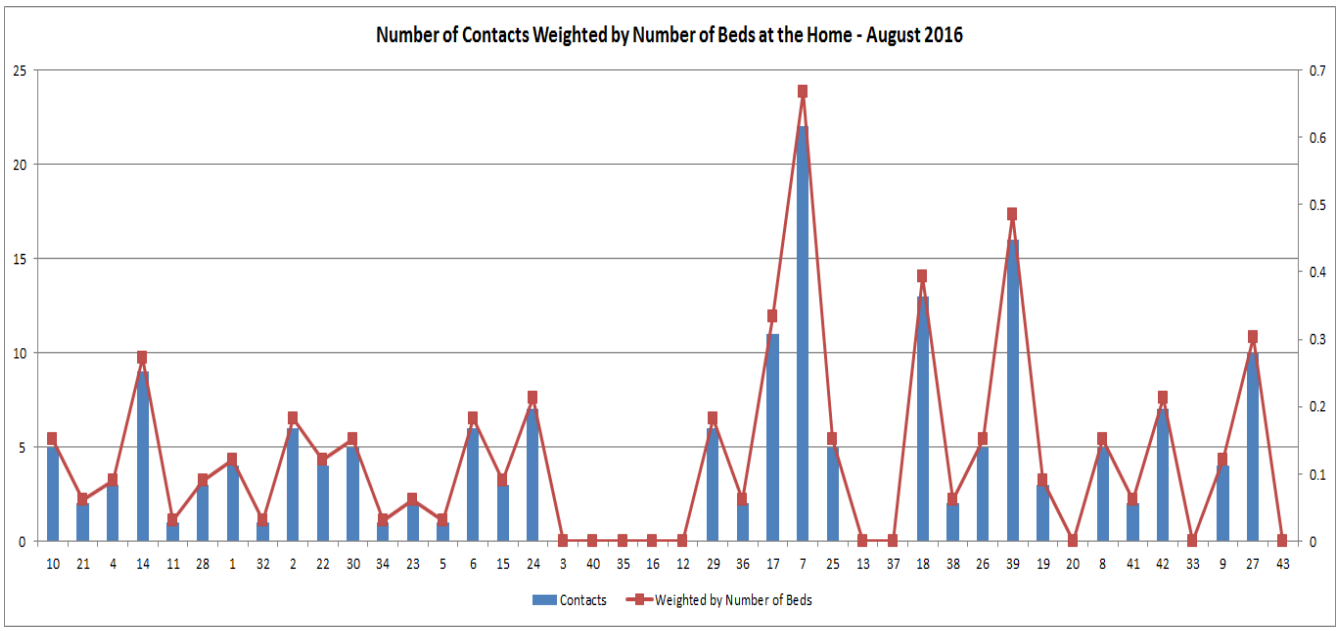
3.32 Over the period Oct 15 to Oct 16 it would appear that the number of A&E attendances (Graph 1) by care home residents has decreased, however it would appear the number of occupied bed days in the chart below has increased (Graph 2). What is more concerning is not only do patients admissions appear to have increased, the length of time (Graph 3) the care home resident is remaining in the acute trust after being deemed to be medically fit has increased significantly (Graph 4). This data has been shared with both the chair of Emergency Care Network and A&E delivery board.

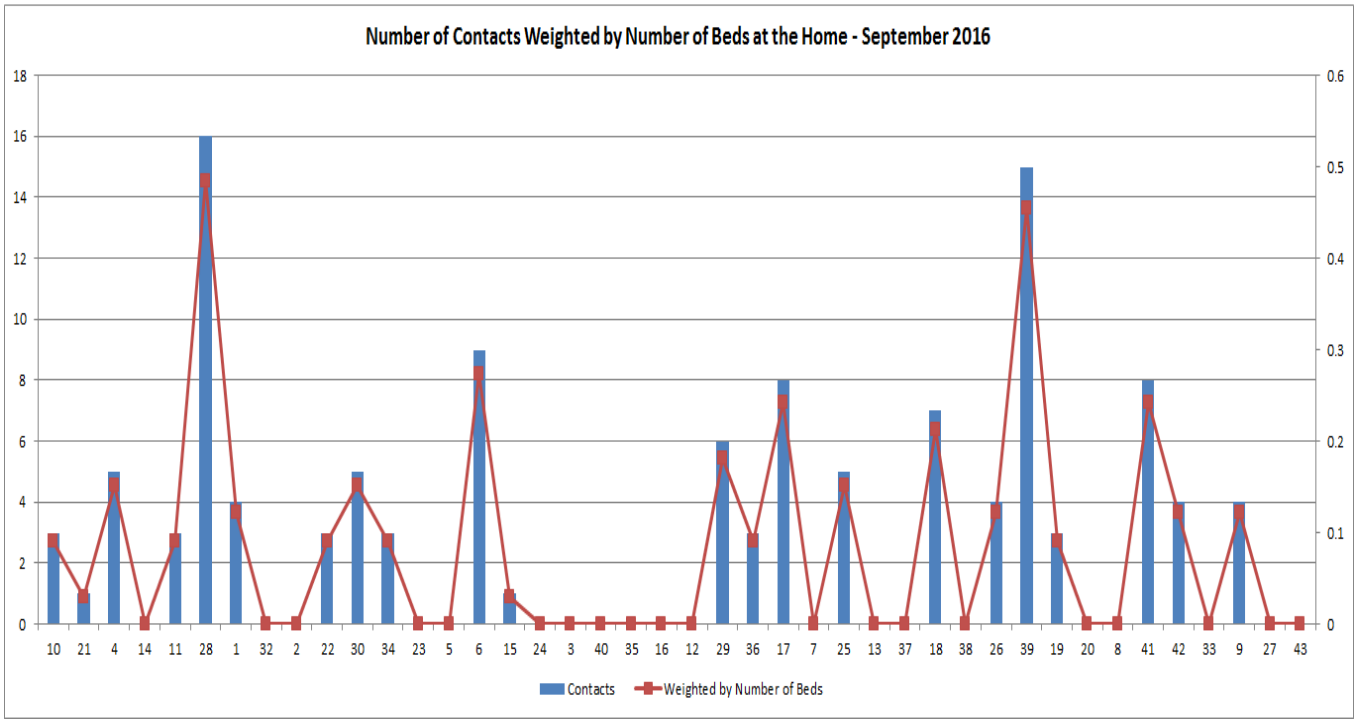






3.33 Go To Doc-In the previous board report we made reference to the importance of the data being analysed by those who understand the care home market. The Charts below highlight an example of this in that on first consideration care home 39 would appear to be a very high user of the go to doc service, however what the data doesn't tell you is that the care home provider has a block contract agreement for spot purchase beds with our local T&G ICFT who commission go to doc to provide the medical cover to those patients.





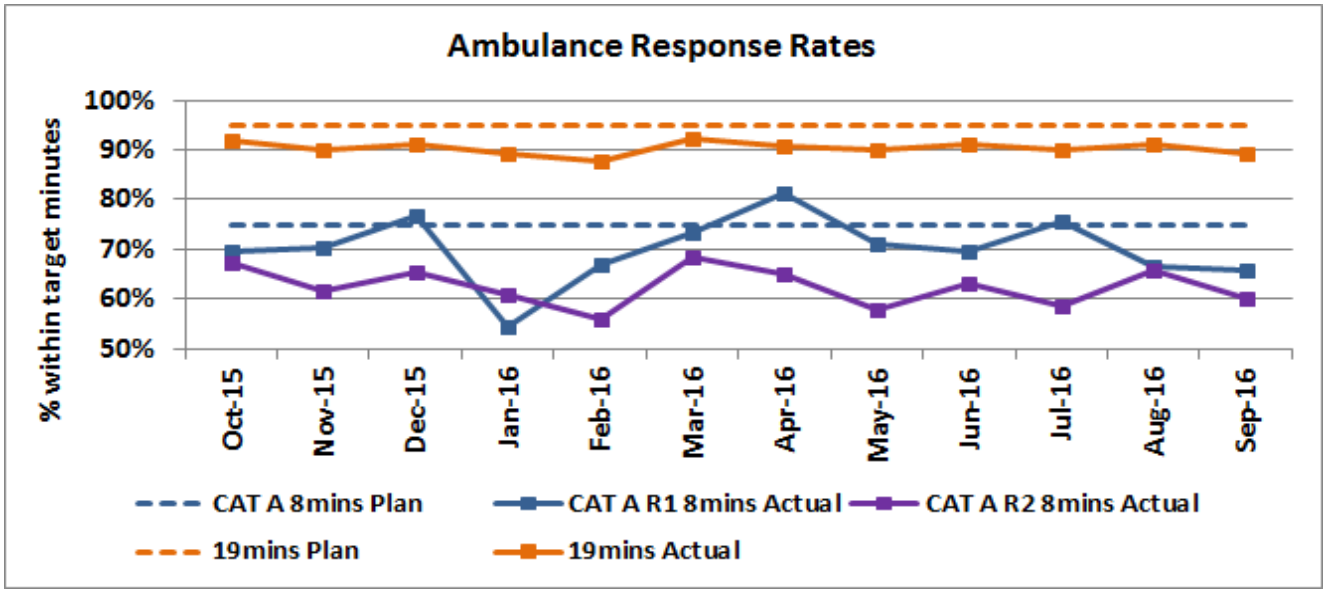
3.34 The care home steering group meets monthly and has access to the full dataset from the urgent care partners. This section will be subject to review as the care home steering group identifies where the priorities within the urgent care system that supports care homes.

3.35 CQC Inspection published in October 2016.

Care Homes with nursing	Outstanding	Good	Requires Improvement	Inadequate	Comments
none					
Care Homes	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**	**Comments**
St Lawrences Lodge	0	0	1	0	Overall: Requires Improvement TMBC supporting home to improve.
PENNINE CARE CENTRE (Glossop)	0	0	1	0	Overall: Requires Improvement On-going support being given by Derbyshire Council. Monitoring visit due Nov 16

Ambulance – please note position reported is September

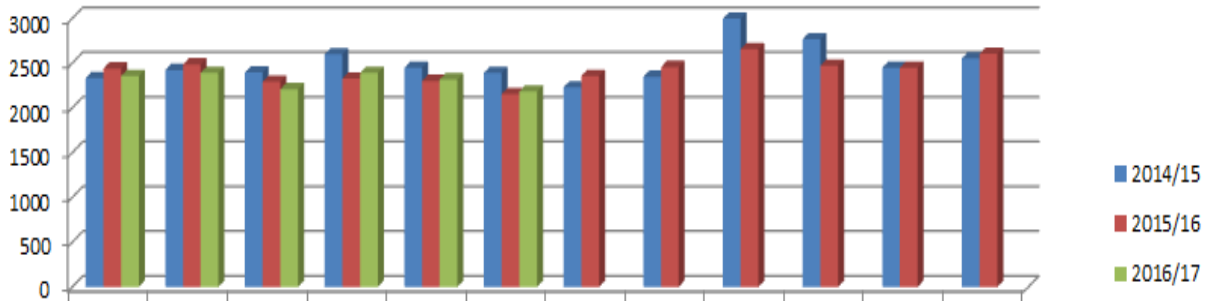
3.36 In August 2016 the CCG failed to achieve the response rates locally with 65.85% for CAT A 8mins Red 1 , 60.03% for CAT A 8mins Red 2 and 89.12% for CAT A 19mins Red 2.



3.37 However, we are measured against the North West position which was 69.49% for CAT A 8mins Red 1; 61.75% for CAT A 8mins Red 2 and 89.04% for CAT A 19mins Red 2 which means none achieved this month.

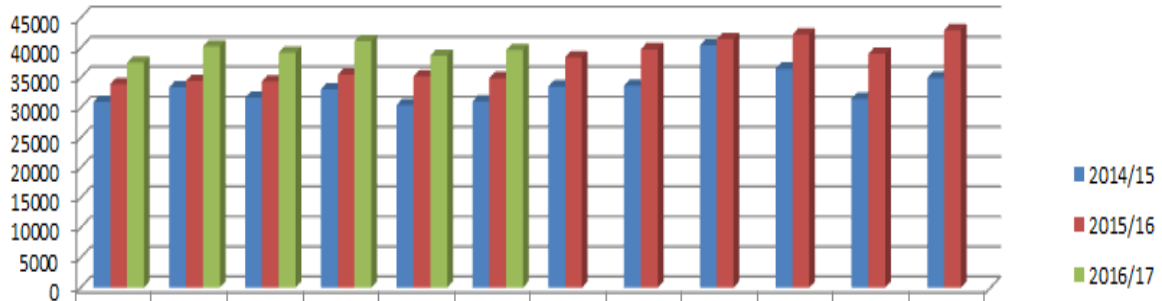
3.38 Increases in activity have placed a lot of pressure on NWAS which has not been planned for. This is impacting on its ability to achieve the standards.

Red 1 <8 Minutes NWAS Activity



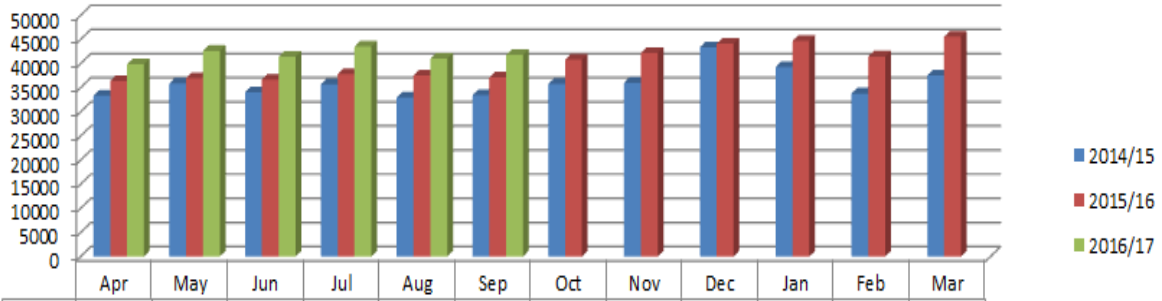
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	2333	2422	2395	2597	2446	2391	2230	2347	2997	2767	2449	2553
2015/16	2439	2485	2292	2327	2300	2155	2357	2456	2655	2469	2449	2604
2016/17	2354	2392	2208	2390	2318	2184						

Red 2 <8 Minutes NWAS Activity



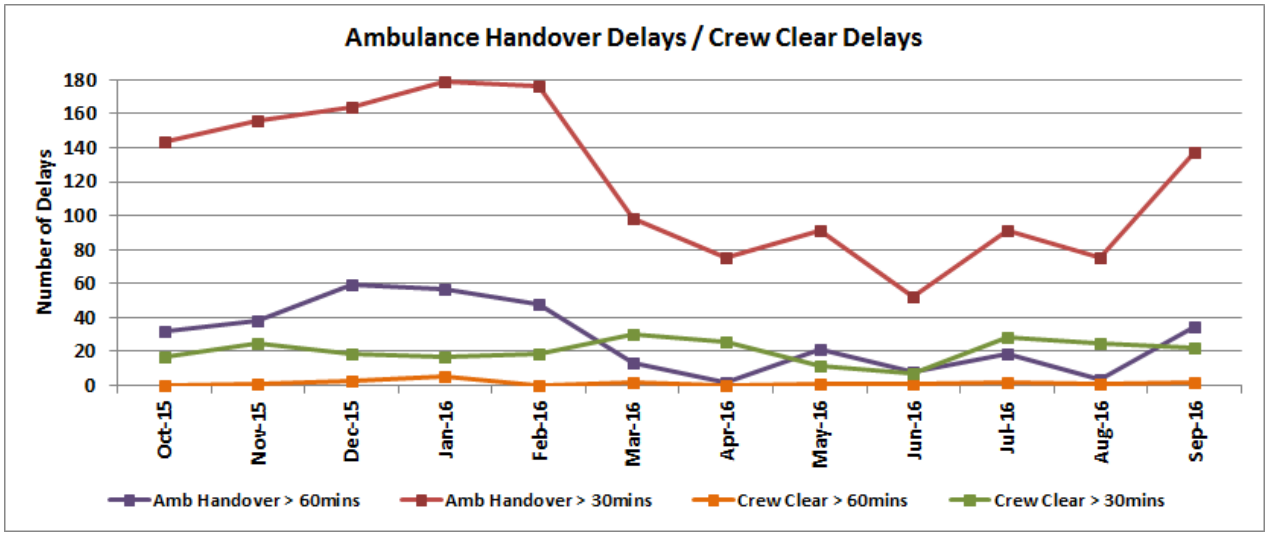
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	30976	33416	31651	33071	30478	31029	33540	33665	40362	36508	31521	34972
2015/16	33939	34473	34374	35485	35216	34942	38414	39743	41435	42203	38992	42951
2016/17	37506	40212	39199	41122	38673	39592						

All Red <19 Minutes NWAS Activity

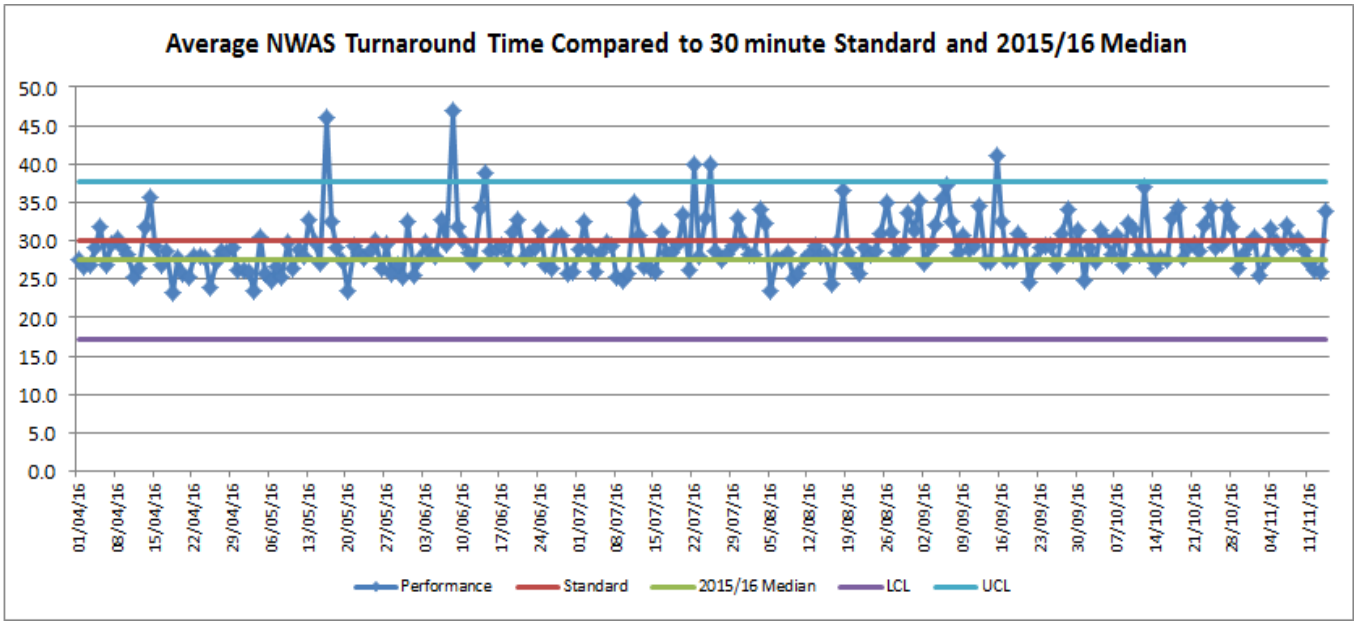


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	33309	35838	34046	35668	32924	33420	35770	36012	43359	39275	33776	37525
2015/16	36378	36958	36666	37812	37516	37097	40771	42199	44090	44672	41441	45555
2016/17	39860	42604	41407	43512	40991	41776						

3.39 The number of ambulances with handover delays increased in September.



3.40 The trend is however still improving for ambulance turnarounds below 30 minutes.



111– please note position reported is September

3.41 111 went live in GM 10th November so this is the tenth full month reported under the new arrangements.

3.42 Primary KPI performance

- The North West NHS 111 service was offered 146,004 calls in the month, answering 123,219.
- 109,904 (89.19%) of these calls were classified as being triaged.

The NW NHS 111 service In September experienced some national technical issues during the period of 10th -15th September which impacted on KPI performance in the month. A full briefing on the issues, causes and impact has been shared with the Strategic Partnership Board. They have continued to work with stakeholders to address themes and trends highlighted within their analysis of HPFs and internally raised incidents.

3.43 The North West NHS 111 service is performance managed against a range of KPI's, however there are 4 primary KPI's which are accepted as common 'currency', reported by each NHS 111 service across England. These are:

	Target	Reported
•	Calls answered (95% in 60 seconds)	88.92%
•	Calls abandoned (<5%)	1.99%
•	Warm transfer (75%)	36.23%
•	Call back in 10 minutes (75%)	33.79%

3.44 The level 4 incidents where ambulances were urgently dispatched to patients who did not want to be resuscitated are being followed up (There was 1 case reported in September). It is essential that GPs share DNACPR with Go to Doc through Special Patient Notes to enable 111 staff to see them and avoid distress to patients and families.

3.45 Our use is in line with NW levels.

	15 and Under	16 to 65	65 and Over	Total
Callers Triaged by Age	756	1,699	654	3,109
% Breakdown	24%	55%	21%	100%
Total for NW Region	24,739	62,991	22,174	109,904
% Breakdown NW Region	23%	57%	20%	100%

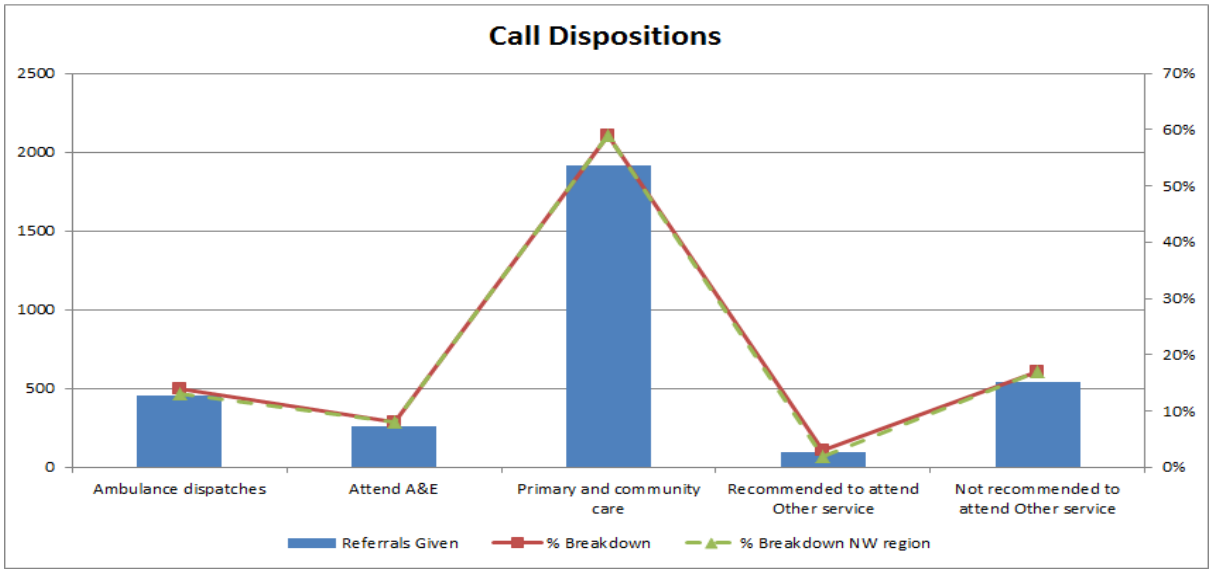
3.46 Our treatment is generally in line with NW levels. Though the number of call backs within 10 minutes was lower than the monthly average across GM by 5%.

	Calls Triaged	Caller terminated call during triage	Callers who were identified as repeat callers	Triaged Patients Speaking to a clinician	Patients Warm Transferred to a Clinician Where Required	Patients Offered a Call Back Where Required	Call Backs in 10 Minutes
Caller Treatment	3,109	297	103	641	242	399	116
% Breakdown	100%	10%	3%	21%	38%	62%	29%
Total for NW Region	109,904	9,937	3,575	22,143	8,022	14,121	4,772
% Breakdown NW Region	100%	9%	3%	20%	36%	64%	34%

3.47 Our onward referral is generally in line with NW levels.

	Calls Triaged	Ambulance Despatches	Attend A&E	Primary and community care	Recommended to Attend Other Service	Not Recommended to Attend Other Service
Referrals Given	3,109	487	250	1,622	61	689
% Breakdown	100%	16%	8%	52%	2%	22%
Total for NW Region	109,904	16,371	9,606	59,978	2,744	21,205
% Breakdown NW Region	100%	15%	9%	55%	2%	19%

3.48 Our dispositions are in line with this.



3.49 The following tables show the 111 data benchmarked nationally. This shows the variation between the NW and the highest and lowest area against the KPIs in the first table and dispositions in the second table.

Indicators - access & quality	T&G CCG	NW inc. Blackpool	NW inc. Blackpool	Highest		Lowest		Notes
Calls per month per 1,000 people		20.2	22	Isle of Wight	40.2	South East London	12.4	
Calls per month via 111 per 1,000 people		20.2	20	Isle of Wight	40.0	South East London	12.4	
Of all calls offered, % abandoned after at least 30 seconds[1]		2%	7	West Midlands	3%	Inner North West London	0%	
Of calls answered, % in 60 seconds		89%	41	Outer North East London	98%	South East Coast	84%	
Of calls answered, % triaged		89%	10	Luton	115%	Buckinghamshire	67%	Data set for Luton looks incorrect
Of answered calls, % transferred to clinical advisor		18%	36	Staffordshire	32%	Inner North West London	14%	
Of transferred calls, % live transferred		36%	32	Isle of Wight	97%	Cornwall	13%	
Average NHS 111 live transfer time[1]		00:00:07						
Average warm transfer time		NCA						
Of calls answered, % passed for call back		11%	30	Devon	22%	Isle of Wight	1%	
Of call backs, % within 10 minutes		34%	32	Cambridge and Peterborough	81%	Dorset	17%	
Average episode length		00:15:37						

Dispositions as a proportion of all calls triaged								
111 dispositions: % Ambulance dispatches	16%	15%	5	NE	17%	South East London	9%
111 dispositions: % Recommended to attend A&E	8%	9%	30	East London and City	14%	Leicestershire and	6%
Recommended to attend primary and community care	52%	55%	42	Cambridge and Peterborough	66%	Inner North West London	47%
Of which - % Recommended to contact primary and community care		41%	23	South East Coast	49%	Inner North West London	32%
- % Recommended to speak to primary and community care		11%	34	Devon	20%	York & Humber	8%
- % Recommended to dental / pharmacy		2%	43	York & Humber	14%	West Midlands	2%
111 dispositions: % Recommended to attend other service	2%	2%	29	NE	8%	South East Coast	0%
111 dispositions: % Not recommended to attend other servic	22%	19%	2	Inner North West London	33%	Oxfordshire	9%
Of which - % Given health information		5%	1	NW inc. Blackpool	5%	Staffordshire	0%
- % Recommended home care		4%	43	Sutton and Merton	8%	Devon	3%
- % Recommended non clinical		11%	6	Inner North West London	26%	Cambridge and Peterborough	2%

4. HEALTH CARE AQUIRED INFACTIONS (HCAIs)

Clostridium Difficile

4.1 The CCG seeks assurance about the arrangements providers have in place for infection prevention and control practice via various mechanisms including:

- Monthly submission of HCAI assurance framework,
- RCA investigation of all positive CDIF and MRSA cases which are monitored for themes and trends at the HCAI Quality Improvement Group,
- CCG Quality Visits include the monitoring and observation of compliance with infection prevention practice as a standard item.

Tameside & Glossop CCG		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	16-17 YTD	16-17 Total
Whole Health Economy	No. of Cases	4	7	3	9	10	5	13	51	51
	Plan	8	10	8	10	6	8	11	61	97
	Variance Against Plan	-4	-3	-5	-1	4	-3	2	-10	-46
	% Variance Against Plan	-50.0%	-30.0%	-62.5%	-10.0%	66.7%	-37.5%	18.2%	-16.4%	-47.4%
Acute	No. of Cases	2	2	2	4	5	2	8	25	25
	Tameside Hospital FT	2	1	1	3	5	2	7	21	21
	South Manchester FT	0	0	0	0	0			0	0
	Central Manchester FT	0	1	0	0	0			1	1
	Christie Hospital FT	0	0	1	0	0			1	1
	Royal Orthopaedic Hospital NHS FT	0	0	0	1	0			1	1
	Stockport FT	0	0	0	0	0		1	1	1
	Plan	4	4	3	4	4	3	5	27	45
	Variance Against Plan	-2	-2	-1	0	1	-1	3	-2	-20
	% Variance Against Plan	-50.0%	-50.0%	-33.3%	0.0%	25.0%	-33.3%	60.0%	-7.4%	-44.4%
Non-Acute	No. of Cases	2	5	1	5	5	3	5	26	26
	Plan	4	6	5	6	2	5	6	34	52
	Variance Against Plan	-2	-1	-4	-1	3	-2	-1	-8	-26
	% Variance Against Plan	-50.0%	-16.7%	-80.0%	-16.7%	150.0%	-40.0%	-16.7%	-23.5%	-50.0%

2016-17 Clostridium Difficile: Tameside & Glossop CCG

4.2 For October 2016 Tameside & Glossop CCG had a total of 13 reported cases of clostridium difficile against a monthly plan of 11 cases. For the month of October this places Tameside and Glossop CCG 2 cases over plan. Of the 13 reported cases, 8 were apportioned to the acute (7 at T&G IC FT, 1 at Stockport FT) and 5 to the non-acute.

4.3 To date (April to October 2016) Tameside and Glossop CCG had a total of 51 cases of clostridium difficile against a year to date plan of 61 cases. This places Tameside and Glossop CCG 10 cases under plan. Of the 51 reported cases, 25 were apportioned to the

acute (21 at T&G ICFT, 1 at Central Manchester FT, 1 at Christie Hospital FT, 1 at The Royal Orthopaedic Hospital FT, 1 at Stockport FT) and 26 to the non-acute.

4.4 In regards to the 2016/17 financial year, Tameside and Glossop CCG have reported 33 cases of clostridium difficile against an annual plan of 97 cases. This currently places the CCG 64 cases under plan with 7 months of the financial year remaining.

MRSA

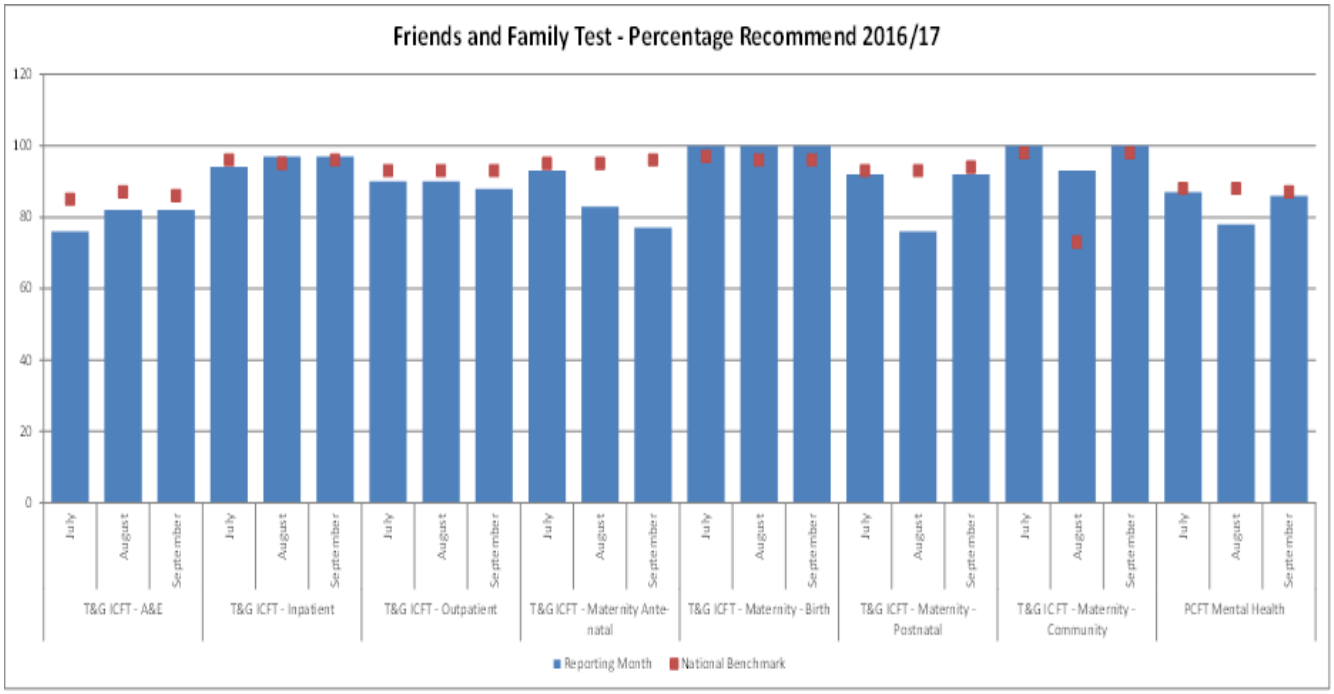
Tameside & Glossop CCG		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	16-17 YTD	16-17 Total
Whole Health Economy	No. of Cases	0	0	2	1	3	0	0	6	6
	Plan	0	0	0	0	0	0	0	0	0
	Variance Against Plan	0	0	2	1	3	0	0	6	6
	% Variance Against Plan	0.0%	0.0%	200.0%	100.0%	300.0%	0.0%	0.0%	600.0%	600.0%
Acute	No. of Cases	0	0	2	0	2	0	0	4	4
	Tameside Hospital FT	0	0	0	0	1			1	1
	Central Manchester FT	0	0	1	0	1			2	2
	University Hospital of South Manchester FT	0	0	1	0	0			1	1
	Plan	0	0	0	0	0	0	0	0	0
	Variance Against Plan	0	0	2	0	2	0	0	4	4
	% Variance Against Plan	0.0%	0.0%	200.0%	0.0%	200.0%	0.0%	0.0%	400.0%	400.0%
Non-Acute	No. of Cases	0	0	0	1	1	0	0	2	2
	Plan	0	0	0	0	0	0	0	0	0
	Variance Against Plan	0	0	0	1	1	0	0	2	2
	% Variance Against Plan	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	200.0%	200.0%

2016-17 MRSA: Tameside & Glossop CCG

4.5 For October 2016 Tameside and Glossop CCG have reported 0 cases of MRSA against a plan of zero tolerance.

4.6 To date (April 2016 to October 2016) Tameside and Glossop CCG have reported 6 cases of MRSA against a plan of zero tolerance. Breakdown includes 4 acute cases (1 at Tameside Hospital FT, 2 at Central Manchester, 1 at South Manchester FT) and 2 non acute cases.

5. FRIENDS AND FAMILY TEST – PROVIDER SUMMARY JUNE 2016 TO AUGUST 2016



5.1 The graph shows performance across the FFT touch-points from July 2016 to September 2016:

- A&E is still lower than the national benchmark although significant improvement has been seen since 2014; this data will continue to be monitored via the T&G IC NHS FT Quality Monitoring meeting.
- The Ante-natal touch point for Maternity has seen a drop the percentage of patients who would recommend the service in the last two months and this will require monitoring, however, PCFT mental health and T&G ICFT postnatal saw improvements in the September 2016 FFT scores.

6. RECOMMENDATION

6.1 As set out on the front of the report.

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

10

GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

Date: 28 October 2016

Subject: Assurance Framework (including Performance Dashboard)

Report of: Jon Rouse and Nicky O'Connor

PURPOSE OF REPORT:

As part of the successful devolution of statutory responsibilities to Greater Manchester, an accountability framework was agreed between NHS England and Greater Manchester which amongst other things, sets out a responsibility to manage and improve system performance and a specific duty to conduct an annual performance assessment of each CCG. The responsibility to undertake this within GM was delegated to the Chief Officer of the Greater Manchester Health and Social Care Partnership.

The report provides an overview of proposed scope of the Assurance & Delivery Framework

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

(i) Note the report and Assurance Framework

(ii) Endorse the Framework as the basis for undertaking assurance on behalf of the Partnership

CONTACT:

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Assurance Framework

Version 1.2

3rd October 2016

1. PURPOSE

This report has the following key purposes:

(i) To set out the scope of the proposed Assurance & Delivery Framework.

(ii) To provide an overview of the method by which assurance will be fulfilled on behalf of GMHSC Partnership

2. CONTEXT

2.1 As part of the successful devolution of statutory responsibilities to Greater Manchester, an accountability framework was agreed between NHS England and Greater Manchester which amongst other things, sets out a responsibility to manage and improve system performance and a specific duty to conduct an annual performance assessment of each CCG. The responsibility to undertake this within GM was delegated to the Chief Officer of the Greater Manchester Health and Social Care Partnership.

3. ASSURANCE PRINCIPLES

3.1 Following the successful agreement of Greater Manchester devolution it was acknowledged that there is a need to construct a new assurance framework to recognise the devolved powers to the Partnership team and which takes account of the broader place-based planning beyond the NHS.

3.2 The core principles by which the assurance framework should be constructed were agreed at a GM Assurance session led by GM system leaders in May 2016. This includes the commitment to an assurance process that reflects place-based leadership and single, integrated locality plans.

3.3 The session considered the vision, principles, strategic aims and outcomes for place-based assurance as:

Vision: GM to be assured, regulated and performance-managed as a PLACE. This would mean that:

- GM is responsible for its own performance;
- Principal accountability sits locally, not nationally;
- Collective responsibility is accepted for performance of the system as a whole;
- GM infrastructure should develop and provide appropriate tools and support.

3.4 The principles for place based assurance, regulation and performance management would be:

- Subsidiarity
- Open, honest, transparent and comparable
- A problem / issue anywhere in our system is all of our problem
- Peer challenge, review and support

- Manage the GM and locality reputation
- Identify and manages risk
- Objective and measurable
- Approach to be able to be modified to situation – support and constructive criticism through to intervention
- Ensure political, clinical and managerial leadership across the programmes
- Facilitate good practice learning and network development.

3.5 The objectives of place-based assurance, regulation and performance approach would be:

- Establish a system which owns the process of assurance and performance improvement, driven by GM determined and owned priorities.
- Enable greater and faster improvement through delivery across all parts of the system, which is engaged in the development and delivery of the process.
- Develop a culture and approach where system peers and partners proactively challenge and support delivery at all levels of the GM system.
- A shared agenda for operational delivery which acknowledges, but is not limited to the requirements of the Mandate and Constitution;
- Immediate means for GM to respond to key areas of delivery risk and use those responses to inform a GM improvement methodology for ongoing application;
- The importance and urgency of GM establishing a competent system dashboard to inform discussion and provide timely oversight of delivery risks.

3.6 The paper - '*GM Taking Responsibility – Recovery, Improvement and Delivery'* was constructed by senior leaders within the GM system which outlines the intent to work as a GM system to design an approach for GM internal assurance that would satisfy the national NHS England requirements, but would also allow our system to design a new approach that ensured that as a collective system we were able to identify our system challenges, collectively agree how we would address those challenges to recover our performance and ensure a sustained improvement and delivery of the agreed outcome. It introduced the idea of a common methodology that could be used at any level (neighbourhood, locality / district, cluster or GM

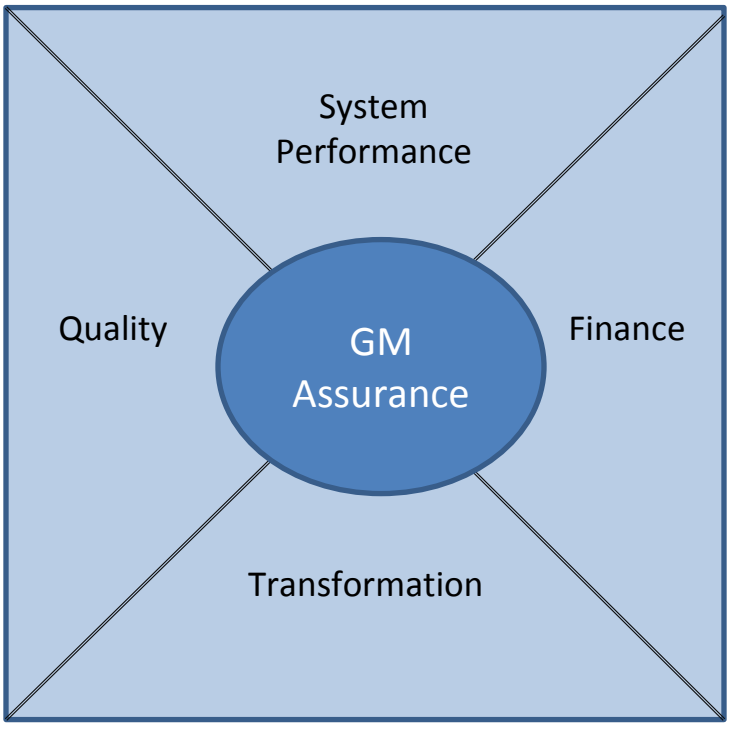
3.7 The paper described the vision, principles and outcomes that a GM methodology would deliver and that the governance we have developed since the signing of the MoU has enabled the GM HSC system to start to work together in a way that has previously proved too challenging on issues such as:

- Connecting the joint work of GM social care Directors to efforts to improve A&E performance;
- Providing for more focused risk based engagement to support safeguarding and failure risk in the care market;
- Recognising the opportunity of the Provider Federation to direct the GM response to key access targets as has been successfully demonstrated on cancer waiting times and survival rates; and
- Supporting greater insights into system delivery by sharing intelligence and developing reports which better illustrate root causes of poor performance.

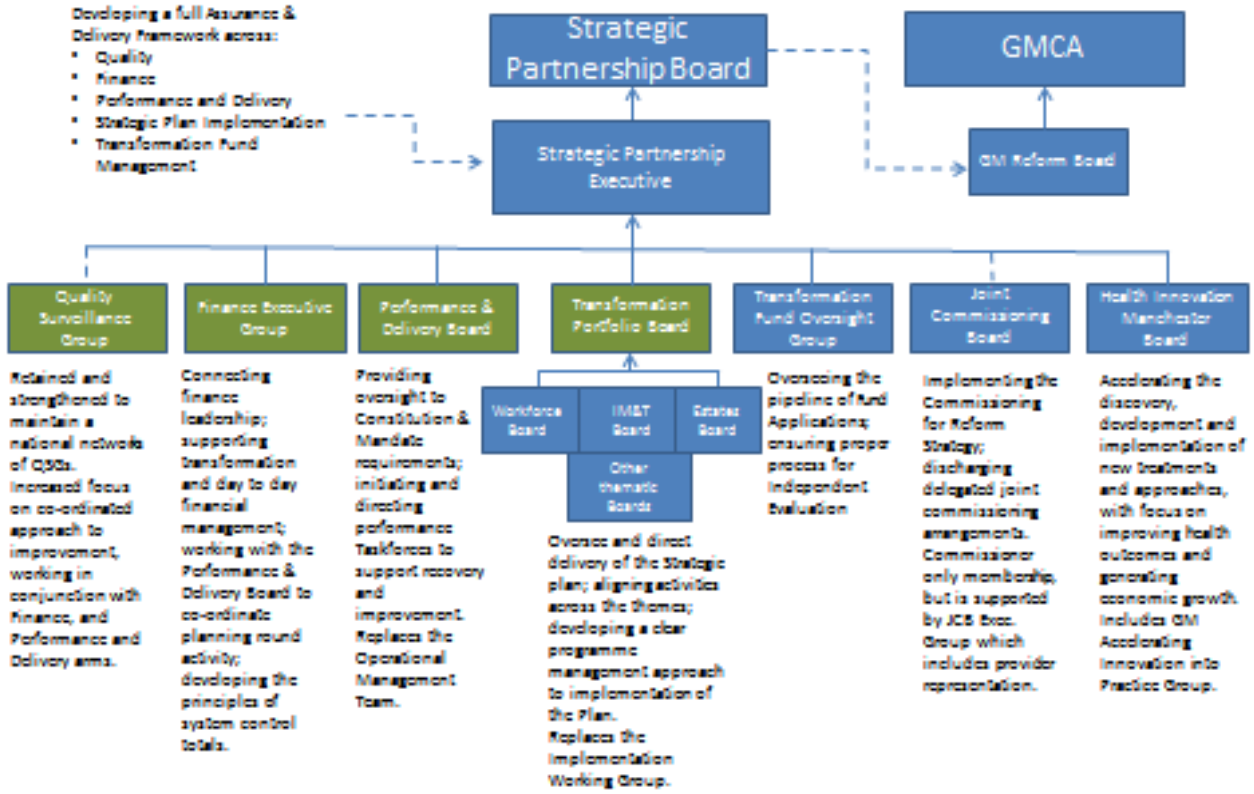
4. THE ASSURANCE STRUCTURE

4.1 The diagram below provides a summary description of the key functions of the assurance and delivery components. The groups and boards have been established with agreed Terms of Reference and appropriate GM system level membership (reflecting the governance considerations in terms of commissioner and provider functions). This is the structure for providing effective assurance and delivery of the Partnership's objectives and will provide the structural context for related work to define operational functionality and reporting mechanisms across individual teams.

4.2 The development of the governance components relating to delivery and assurance aims to ensure a co-ordinated approach towards improvement, performance and delivery. This is reflected in the renewed emphasis placed on the Quality Surveillance Group to work in conjunction with the Finance and Executive Group and the Transformation Portfolio Board, all feeding into the Performance and Delivery Board. This will ensure that the Strategic Partnership Executive will have a comprehensive and timely overview of issues and system support activities in these key areas. The Performance and Delivery Board will have ownership of the assurance framework which will provide a shared source of intelligence to drive the work of the related assurance and delivery groups, this will be supported but a balanced scorecard which will focus on the key areas of system performance, finance, transformation and quality.



Assurance & Delivery



4.1 Quality

4.1.1 Quality Surveillance Groups (QSGs) are a requirement of the National Quality Board and allow system oversight and identification of thematic issues across a health economy. The purpose of the QSG is to not only meet the requirements of the Francis Inquiry but also to ensure that "quality is systemic" for patients. This is done by assuring the complex set of interconnected roles, responsibilities and relationships that exist between professionals, provider organisations, commissioners, and regulators.
Within GM the QSG is chaired by the Exec Lead for Quality of the Partnership,(who is also the MD); membership includes Chief Operating Officers of CCGs, CQC, NHSI, HEE, PHE and Healthwatch.

4.1.2 The QSG acts as a virtual team across a health economy, bringing together organisations and their respective information and intelligence, gathered through performance monitoring, commissioning, and regulatory activities. By collectively considering and triangulating information and intelligence, QSGs work to safeguard the quality of care that people receive.

4.1.3 Once a Quality Surveillance Group identifies concerns about the quality of care being provided in their area, members can take contractual action, regulatory/enforcement action and/or provide improvement support in line with their existing responsibilities. QSGs are not statutory bodies: they have no legislative status or formal powers. QSGs are a forum through which different organisations who do have statutory powers and responsibilities can come together to discharge their responsibilities in a more informed and collaborative way.

4.1.4 Their purpose is not to performance manage Clinical Commissioning Groups (CCGs) or any other organisations, and they should not interfere with the statutory roles of constituent organisations e.g. contractual powers or regulatory responsibilities. They will not substitute the need for individual organisations to act promptly when pressing concerns become apparent.

4.1.5 Local QSGs can take action in the following form:

- investigations by individual member organisations, e.g. the commissioner(s), CQC, Public Health England, NHSI
- triggering Risk Summits (which may include the provider(s) in question) – where there are concerns that a provider is potentially or actually experiencing serious quality failures;
- deciding to keep the provider under review – where there are concerns about a provider that do not yet merit triggering a risk summit.

4.1.6 Single Item QSG Triggers include:

- Lack of confidence in the providers ability to improve
- Serious patient safety concerns
- Serious contract breaches/Contractual notices
- Issues outside of providers' control
- Persistent failure to meet CQC standards
- CQC Special Measures

4.1.7 Risk Summit Triggers

- serious failings within a provider
- a need to act rapidly to protect patients and / or staff
- a single, material event

4.1.8 Information gathered at QSG will form part of the Assurance framework: triangulated data from members will give insight into the quality of services commissioned. Whilst QSGs have not previously considered the quality of commissioned social care, under the GMHSCP, this, along with ownership of the overall framework for quality improvement in GM, will be reflected in new terms of reference to be agreed 6th October 2016.

4.2 Transformation

4.2.1 The Transformation Portfolio Board is responsible for the oversight and direction of the delivery of The Greater Manchester strategic plan – Taking Charge.

4.2.2 The Transformation Portfolio Board will bring together locality leadership with the GM transformation theme and programme leads to oversee and drive delivery of the GM transformation portfolio, direct and prioritise key GM level programmes of work and resolve key delivery issues/risks that are GM wide. It will be responsible for overseeing the implementation, delivery, alignment and prioritisation of the transformation portfolio and ensuring progress is being made across all areas.

4.2.3 The Board will ensure that risks and issues and pro-actively identified and managed. The members will model the system impact of the transformation portfolio in the context of wider public sector reform and delivery of business as usual. There will be a focus on the delivery of benefits realised as a result of plans being implemented, especially as Transformation Funds are allocated.

4.2.4 The Transformation Board will provide a monthly report into the Strategic Partnership Board Executive to provide assurance on the management of risks and issues, as well as progress of critical activities. This report will be considered as part of the locality assurance process.

4.3 Finance

4.3.1 The Executive Lead for Finance and Investment will be reviewing the relevant governance of the Partnership. However, what we know is that there will be a dedicated Board (currently called the Finance Executive Group) that will provide a forum for the consideration of strategic financial issues and assessment of associated financial risks, and, to coordinate and lead action where appropriate of the GMH&SC agenda. The table below outlines the proposed reporting and assurance processes to be undertaken by FEG, yet to be finalised.

Area	Comments	Recommendation
Reporting		
1. To include financial assurance ratings under the locality reporting arrangements that are being developed	A separate work stream is underway to develop a monthly financial locality report for GM. An initial plan locality report has been taken to FEG, and a month 2 in-year report will shortly be shared. Develop from this an understanding of the ability of the GM economy to meet planned financial targets.	It is proposed that assurance ratings from existing assurance regimes will be added to this locality report from month 3 Out of this, work with NHS England / NHS Improvement to understand and influence the treatment of CCGs' 1% uncommitted reserve
2. Locality plans	Assurance ratings are currently given to 5 year locality plans in terms of being ready to bid against and access the Transformation Fund. Consider the relationship between these ratings, and ratings from the existing financial assurance regimes	Look to add locality plan updates and ratings to the monthly locality report
3. Consider a new single composite financial assurance rating at locality level		Propose a review to develop a financial assurance scorecard by locality with a single combined assurance rating
4. Reporting of other financial metrics	QIPP / CIPs will be included in the proposed monthly locality report. Consider reporting other metrics such as the use of cash; run rates; underlying positions and capital, as a means of improving overall assurance. This would all based on information that is already available from existing returns	Propose a review of other metrics, including suitable explanations where metrics need interpretation (for example where different definitions apply between sectors)
5. Self-reporting at a locality level	Consider longer term options for localities to self-report	Review work in Tameside in particular on locality reporting to promote good practice
6. Link with other areas of assurance	Link the reporting of financial assurance with ongoing discussions	Link in with wider devolution work to develop a consistent

	on future assurance arrangements in other areas of performance	assurance regime across GMH&SC
Interventions		
7. Principle that existing assurance regimes apply unless otherwise agreed	For the sake of clarity; • Share details of existing assurance regimes • re-iterate that all existing assurance guidance and regimes continue to apply unless or until new local guidance is approved	Suggest update from the FEG group
8. Recovery plans	To recognise the dynamic that; • NHS England / NHS Improvement remain statutorily responsible for assurance of individual organisations • The recovery plan of an individual organisation affects other local organisations and sectors	Work up guidance on how organisations that need a recovery plan should work within the context of a locality wide recovery plan Consider how GMH&SC / NHS England / NHS Improvement can work together over joint solutions to the recovery plans of individual organisations
9. "Step-in rights"	To note that discussions are ongoing with the NHS England regional team over "step-in rights"; ie what are the relative roles of the regional team and the GMH&SC partnership on financial assurance, and being "assured, once as a place"	To note and feed into local reports once agreement has been reached. Consider the impact of other sectors
10. Cross sector assurance	Clarify how communications can work across the sectors of CCGs, providers and LAs to help achieve performance targets	Develop proposals such as quarterly tripartite assurance meetings, recognise capacity constraints in how this is progressed
11. Self-assurance within sectors	At one stage of the 16/17 planning process, GM CCGs were failing collectively to meet their drawdown control total. GM CCG CFOs discussed how CCGs could collectively manage situations like this. Ie to review flexibilities around individual organisation / collective control totals to ensure the GM-wide	Sectors, particularly CCGs, to consider whether any principles can be developed for self-assurance within sectors

	position can be managed. Agreement was subsequently reached over how this could be managed.	

4.4 System performance

4.4.1 Within existing GMHSC partnership governance arrangements the Performance and Delivery Board will be the Board where all performance requirements are considered together. It is also, however, the monthly forum where constitutional mandate standards are specifically reviewed along with the appended partnership outcomes; this includes the CCG Improvement and Assurance Framework metrics. The emphasis of the meetings is to evaluate performance and delivery at a GM level, and whilst recognising different priorities exist in the partnership organisations it is essential that GM works as a collective system to achieve the common goals and ambitions of the partnership and provide peer support and challenge. The Performance and Delivery Board may initiate and direct performance taskforces to provide support where appropriate (see below).

4.4.2 Members of the Performance and Delivery Board are nominated system representatives from within each sector of the partnership to enable a genuine multi-sectorial approach, the members act in an advisory capacity and make judgements in relation to system challenges and risks. This will included directly commissioned services and primary care.

4.4.3 The Performance and Delivery Board reports into the Strategic Partnership Board Executive (SPBE) enabling the SPBE & Strategic Partnership Board to take a more holistic view of the 'state' of the place.

4.5 The performance dashboard

4.5.1 A performance dashboard (Appendix Two) is being developed to provide oversight to the Performance and Delivery Board. The dashboard is intended as a focal point for joint work, support and dialogue between the Partnership and localities. Data will be updated monthly for the constitutional standards whereas many of the other indicators are updated on a quarterly, or in some cases, annual basis. This will enable everyone to see, in-year, what is working well and what is off-track. The Partnership will work together to ensure that the breadth of the dashboard is discussed with all stakeholders and it will form part of the Assurance Framework during the year, through a rolling programme of local conversations, drawing on expertise and insight from all sectors.

4.5.2 The CCG Improvement and Assessment Framework dashboard was used as the starting point for the dashboard. It has been built upon to incorporate further appropriate indicators which will help drive and monitor the success of the partnership. The dashboard includes indicators representing all partnership organisations to ensure a comprehensive lens which encapsulates the interdependencies of each sector. As outlined in the assurance process below, the dashboard will encompass the four elements of system performance, quality, finance and transformation. It will cast across public health, NHS and social care.

4.5.3 The performance dashboard must flow from the agreed outcomes framework and plans are in place to broadly align the outcomes with the performance metrics. The outcomes framework will be a value measure to the progress and impact of transformation schemes and act as a longer term indicator of the success in achieving the ambition of improving the health, wealth and wellbeing of the population of Greater Manchester.

4.5.4 The appended Performance Dashboard is currently in draft format and subject to further development and change. We are open in this development phase to views on choice of indicators and there is work to be done to turn the dashboard into a proper balanced scorecard that creates the right conversations. We also need to develop the right presentational form that communicates progress to wider groups of stakeholders, including elected representatives and the wider public.

4.6 Taskforce Groups

4.6.1 System performance issues will at times require focussed attention to enable a multi-sectoral approach to generate sustainable solutions. By working together, NHSE and GM will be able to fully understand and manage risk together and take more control of its own future and responsibilities

4.6.2 Urgent care is an example whereby it has been possible to make use of the new governance available to the devolved system in GM by establishing an Urgent Care Taskforce. The Taskforce is responsible for making links with and ensuring alignment between a range of programmes and initiatives that will support improved access and experience for people requiring urgent or emergency care.

4.6.3 Progress will be monitored by the Performance and Delivery Board along with input from NHS Improvement.

4.6.4 A similar approach can be adapted to other specialist areas where a cohesive response is required.

5. THE ASSURANCE PROCESS

5.1 It is proposed to undertake CCG Assurance within the context of locality planning by holding quarterly meetings with the executive leads of GMHSC and the leaders of the localities. There is a requirement for the CCG executive team to be represented at these meetings to satisfy the statutory requirement. However, there is also an intention to use these meetings to signal how we do assurance differently in GM, providing the opportunity to take a holistic approach that is cross-sectoral and covering all the bases of the Locality Plan, whilst still enabling the discharge of statutory functions. All partners have joint responsibility for helping each other transform and sustain the GM health and social care systems. The purpose of engendering mutual assistance and taking timely action where needed, should be as valuable as the formal act of annual assessment.

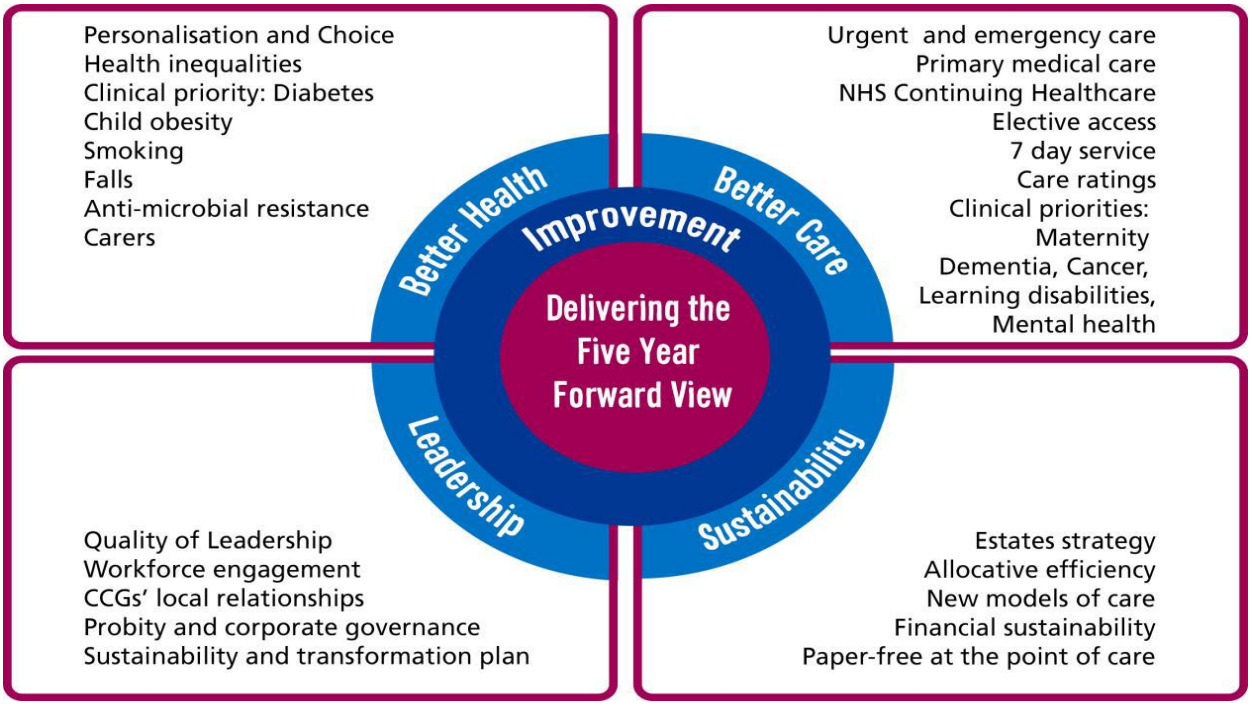
5.2 The assurance process will support conversations with other boards and allow for co-ordinated conversations to take place and avoid the need for multiple conversations, it will allow for a holistic approach whilst still enabling the discharge of statutory functions.

It is our intention under the new arrangements to involve NHS Improvement in these meetings, as well as receiving support and input from other national bodies as required in order to prevent contradictory support/guidance.

5.3 The process will recognise the Partnership's duty to provide accountability to the population of Greater Manchester that transformation is being carried out on their behalf.

5.4 The meetings will need to cover the Improvement and Assessment Framework (IAF) which encompasses the four elements of Better Health, Better Care, Sustainability and Leadership, along with delivery, quality, finance and transformation.

- Better Health: this section looks at how localities are contributing towards improving the health and wellbeing of its population, and bending the demand curve;
- Better Care: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
- Sustainability: this section looks at how localities remain in financial balance, and is securing good value for patients and the public from the money it spends;
- Leadership: this domain assesses the quality of the localities leadership, the quality of its plans, how the system works in partnership, and the governance arrangements that the locality has in place to ensure it acts with probity, for example in managing conflicts of interest.



5.5 But wherever relevant we will consider these issues on a cross-sectoral basis. Thus, the meetings will recognise joint responsibility and focus on mutual assistance and practical support where needed

5.6 Topics for discussion will include:

- Operational performance
- Quality of care
- Finance and use of resources
- Transformation fund metrics
- Leadership
- Improvement support requirements
- Success stories and areas of best practice; and, crucially
- Progress towards Improved Outcomes

5.7 These meetings will be supported by business intelligence including performance against constitutional standards and mandate commitments, IAF and quality indicators, outcomes framework and financial position. Transformation fund metrics will provide the generation of good evidence to track the impact of investments and support on levels of demand within the system. It is also an opportunity for the locality partners to say what more they need from the GM Partnership and national bodies.

5.8 These meetings will help inform the assessment of the non-data driven indicators within the IAF for which the GMCO is responsible.

5.9 Greater Manchester Quarterly Performance Meetings with NHS England

5.9.1 Within the Accountability Agreement in place between NHS England and Greater Manchester there is a continuing responsibility, through the GM Chief Officer (GMCO), for NHS organisations to deliver the NHS Constitution, observe statutory requirements and account to national Arm's Length Bodies where appropriate for the outcomes achieved on improving health and wellbeing, quality, performance and finance.

5.9.2 NHS England and the GM Chief Officer meet on a quarterly basis to assess the position of the NHS in Greater Manchester. Assurance discussions recognise the first accountability of public services is to the populations they serve and are undertaken in the context of the 'place'. They recognise that the GM Health & Social Care Partnership has formal accountabilities to the population of Greater Manchester as well as statutory accountabilities for NHS bodies to national Arm's Length Bodies.

5.9.3 Formal assurance of Greater Manchester is undertaken in aggregate but there is opportunity for discussion about individual places or organisations where warranted by the thresholds in the Accountability Agreement.

6. INTERVENTION AND ESCALATION

6.1 The Accountability Agreement says that in the first instance where GMH&SC is not delivering the requirements of the NHS Constitution, mandate, finance business rules and agreed finance control totals at an aggregate level the GMH&SC team will set out

for NHS England's regional team its proposal for improvement. The required actions could include:

- an improvement/recovery plan
- monitoring of the standard at a different frequency (eg monthly)
- a requirement for GM to seek further prescribed support to secure recovery
- NHS England exercising its powers of intervention with an individual CCG

6.2 Included in the agreement are thresholds where improvement plans are required and also for what are described as step-in rights on behalf of NHS England. These potential responses are seen as being part of a spectrum of activity through potential levels of escalation if this is agreed to be necessary. Escalation can be seen as working both ways, for example the GMCO may wish to ask NHS England to use its formal powers of intervention or NHS England stepping in might lead to escalation within GM. Where NHS England is considering whether to exercise its step in rights there will be a discussion with the GMCO. The concept of step in is based on NHS England working through the GMCO and then both parties agreeing how to work to address the issues that have been identified. An example would be where individual CCG/place performance is below the threshold described in the Accountability Agreement or agreed financial control total then in the first instance an Improvement Plan will be requested from the GMCO that will set out how the position with the organisation/place will be returned to the required standard. Where individual CCGs are consistently outside the thresholds in the Agreement or agreed financial control total then GM Health and Social Care Partnership. will manage improvement in partnership with the regulatory bodies. In cases where improvement has not been realised then GM Health and Social Care Partnership. can seek additional improvement support from NHS England's regional team.

6.3 Where individual CCG performance is outside of agreed tolerances within the Accountability Agreement the GMCO has an obligation to provide assurance on behalf of GM in the form of improvement plans and recovery trajectories. Powers of intervention are retained by NHSE for sustained non-delivery.

6.4 CCG Escalation and Intervention

6.4.1 A CCG assessment moving down to limited assurance or not assured in a particular component would signal the need for an improvement plan. An improvement plan could form part of the application of special measures or legal directions. The CCG improvement and assessment framework does not make in year assessments to provide these triggers. However, the process remains the same. If the data, or wider sources of insight, raise concerns that initiate a discussion between GM Health and Social Care Partnership in conjunction with NHS England and a CCG, the outcome could be an improvement plan. If the circumstances match the description of special measures or the statutory definition of directions, these actions may also be taken.
NHS England is supported by legislation in exercising formal powers of direction if it is satisfied that a CCG is (a) failing or (b) is at risk of failing to discharge its functions.
Formal intervention action would be proposed, as laid out in section 14Z21 of the NHS Act 2006 (as amended)

6.4.2 Since the use of direction affects CCG autonomy, careful consideration is required before this course of action is implemented. Any proposed such intervention should be

appropriate to the risk identified. When considering the use of intervention powers, a number of steps need to have been taken in order to establish whether the use of such powers is proportionate and appropriate.

6.5 Provider Escalation and Intervention

6.5.1 **NHS Improvement** support foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

6.5.2 Providers are segmented based on how closely they meet NHSI's single definition of success. Higher performing providers are allowed greater freedoms, including fewer data and monitoring requirements and simpler processes for transactions. More challenged providers will be given more direct and tailored support to help stabilise and improve their performance.

6.5.3 **CQC** are the independent regulator of health and adult social care in England. The role of CQC is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

6.5.4 CQC work to ensure that services found to be providing inadequate care do not continue to do so. Therefore they have introduced special measures. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which is used for enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration.

6.5.5 There are some differences in the process CQC use for special measures in different sectors including primary medical, independent healthcare and adult social care services.

6.5.6 Special measures apply to NHS trusts and foundation trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Special measures consist of a set of specific interventions designed to improve the quality of care within a reasonable time.

6.5.7 In this approach the Care Quality Commission (CQC) will focus on identifying failures in the quality of care, judging whether improvements have been made and, where necessary, using its enforcement powers to ensure that providers who are unable to meet required standards of quality and safety are not allowed to continue indefinitely. NHS Improvement uses their respective powers to support improvement in the quality.

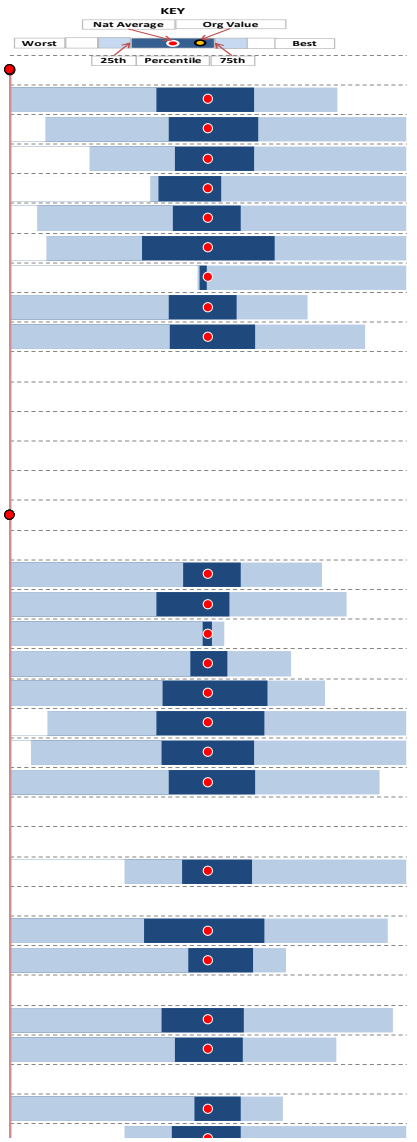
6.6 **Local Authority Escalation**

6.6.1 Local authorities are autonomous elected bodies operating under a separate statutory framework. Serious failure to fulfil statutory duties will be a matter for the Secretary of State for Local Communities or, in the case of care commissioning functions, could also be a matter for the Secretary of State for Health under section 48 procedures following a requested CQC review.

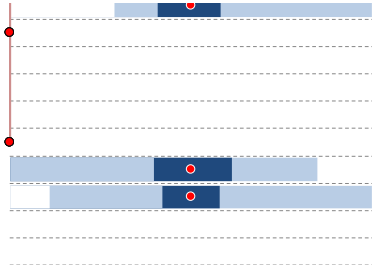
6.6.2 With respect to the Partnership's work we would seek to rely wherever possible on mutual support mechanisms, and also the local scrutiny function, including, at GM level, the Joint Health Scrutiny function that has the ability to call in anything that impacts residents on a pan GM footprint.

APPENDIX

	Improvement and Assessment Indicators	Latest Period	GM / STP	England	Trend	Better is...
	Better Health					
▲	Maternal smoking at delivery	15-16 Q3	12.8%	10.6%		L
◀▶	% children aged 10-11 classified as overweight or obese	2014-15	34.6%	33.2%		L
▼	Diabetes patients that have achieved all three of the NICE-recommended treatment targets	2014-15	41.8%	39.8%		H
▲	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	1.9%	5.7%		H
◀▶	Injuries from falls in people aged 65 and over per 100,000 population	01-Nov-15	0	2027		L
◀▶	Personal health budgets per 100,000 population (absolute number in brackets)	15-16 Q4	34	14		H
▲	% deaths which take place in hospital	15-16 Q3	50.5%	46.9%		L
▼	People with a long-term condition feeling supported to manage their condition	2015	0.0%	64.4%		H
◀▶	Inequality in avoidable emergency admissions	15-16 Q2	0			L
◀▶	Inequality in emergency admissions for urgent care sensitive conditions	15-16 Q2	0			L
	Medicine Optimisation **(Place Holder)**					
	Better Care					
◀▶	Cancers diagnosed at early stage	2014	0.0%			H
	People referred by their GP with suspected cancer within two weeks	Jul-16	95.5%	94.4%		H
	People referred by their GP with suspected cancer (breast symptoms) within two weeks	Jul-16	86.9%	92.1%		H
	People receiving first definitive treatment within 31 days of a cancer diagnosis	Jul-16	99.2%	97.8%		H
	People receiving subsequent cancer treatments -surgery within 31 days	Jul-16	96.1%	96.0%		H
	People receiving subsequent cancer treatments -anti cancer drug regimens within 31 days	Jul-16	100.0%	99.4%		H
	People receiving subsequent cancer treatments - radiotherapy within 31 days	Jul-16	100.0%	97.4%		H
▼	People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral	Jul-16	89.2%	82.2%		H
	People receiving first treatment for cancer following a consultant's decision to upgrade the patients priority within 62 days	Jul-16	85.9%	89.3%		H
▲	One-year survival from all cancers	2013	0.0%	70.2%		H
	Improving Access to Psychological Therapies access rate					
▲	Improving Access to Psychological Therapies recovery rate	Jun-16	45.5%	48.8%		H
	Improving Access to Psychological Therapies seen within 6 weeks	Jun-16	74.4%	88.5%		H
	Improving Access to Psychological Therapies seen within 18 weeks	Jun-16	94.7%	98.5%		H
▼	People with 1st episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referr	Jul-16	84.7%	74.6%		H
▼	Estimated diagnosis rate for people with dementia	Aug-16	77.0%	67.3%		H
◀▶	People with a learning disability and/or autism receiving specialist inpatient care per million population	Mar-16	0	58		L
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	0.0%	47.0%		H
◀▶	Neonatal mortality and stillbirths per 1,000 births	2014-15	8.0	7.1		L
◀▶	Emergency admissions for urgent care sensitive conditions per 100,000 population	15-16 Q2	0			L
▲	% patients admitted, transferred or discharged from A&E within 4 hours	Jul-16	87.7%	90.3%		H
▲	Delayed transfers of care attributable to the NHS and Social Care per 100,000 population	Apr-16	13.6	13.0		L
◀▶	Emergency bed days per 1,000 population	15-16 Q2	0.0			L
◀▶	Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population	2014-15	0.0	811.8		L
▼	Patients waiting 18 weeks or less from referral to hospital treatment	Apr-16	93.2%	91.7%		H
	Diagnostics Test Waiting Times	Jul-16	2.6%	1.8%		L
◀▶	People eligible for standard NHS Continuing Healthcare per 50,000 population	15-16 Q3	54.9	47.9		H
	C.Difficile (YTD Var to Plan)	Jul-16	-8.9%	-5.4%		L
	MRSA	Jul-16	4	32		L
	Primary Care (Place Holder)					
	Primary care access					
	My NHS					
▼	People offered choice of provider and team when referred for a 1st elective appointment	Feb-16	0.0%	50.0%		H
▼	Cancer patient experience	2014	89.8%	89.0%		H
◀▶	Patient experience of GP services	Jan-00	0.0%	0.0%		H
▲	Quality of life of carers - health status score (EQ5D)	2015	1.9			H
◀▶	Women's experience of maternity services	Jan-00	0.0	0.0		H
◀▶	Choices in maternity services	Jan-00	0.0%	0.0%		H



	Sustainability				
◀▶	Financial plan	2016			H
◀▶	Digital interactions between primary and secondary care	15-16 Q4	0.0%		H
◀▶	Local strategic estates plan (SEP) in place	2016-17	0.0%		H
	Activity v Plan: Total Referrals (Specific Acute)	July-16 (cum)	0.0%	2.3%	-
	Activity v Plan: Total OP attends (Specific Acute)	July-16 (cum)	-3.9%	-0.7%	-
	Activity v Plan: Total Elective spells (Specific Acute)	July-16 (cum)	-0.4%	-2.4%	-
	Activity v Plan: Non-elective spells complete (Specific Acute)	July-16 (cum)	-0.4%	1.1%	-
	Activity v Plan: Attendances at A&E (All Types)	July-16 (cum)	1.7%	3.3%	-
	Well Led				
◀▶	Staff engagement index	2015	0.0	3.8	H
◀▶	Progress against Workforce Race Equality Standard	Jul-05	0.0	0.2	H
◀▶	Effectiveness of working relationships in the local system	2015-16	0.0		H
◀▶	Quality of CCG leadership	2016-17			H
	Social Care				
	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	Ap15 - Mar16			L
	Proportion of people using social care who receive self-directed support, and those receiving direct payments	Ap15 - Mar16			L
	% of people aged 65+ discharged direct to residential care	Ap15 - Mar16			L
	Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population	Ap15 - Mar16			L
	No of bed days - delayed transfers of care aged 18+ per 100,000 pop	Apr-16			L
	Worforce (Placeholder)				
◀▶	Primary care workforce - GPs and practice nurses per 1,000 population	2015	0.0		H



Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 December 2016
Officer of Single Commissioning Board	Angela Hardman, Director of Public Health and Performance, Single Commissioning
Subject:	**HOMESTART HOME VISITING AND BEFRIENDING SERVICE AND TWO YEAR OLD FREE EARLY EDUCATION ENTITLEMENT SUPPORT**
Report Summary:	The economy faces significant challenges in working to reduce demand within Children's Services within the available budgets. There is therefore a need to continue to work closely with and support key providers within the local voluntary sector with whom we have existing positive arrangements that support these requirements moving forward. Work on how best to commission support to families and maximise available budgets has been on-going since earlier this year. Agreement in early September 2016 was reached to commission a single more holistic low level family support service. The new service will be designed with the existing provider to better target vulnerable families by using supervised peer supporter volunteers, by doing this it is hoped that a more sustained asset based approach can be achieved. The new service will support reducing demand in Early Help and Children's Social Care and complement the transformation programme in 2017/18, which will start the delivery an integrated children's and family services. This will require all agencies locally to understand and collaborate on arrangements for delivering an integrated children and families offer. The work will be aligned to the Integrated Neighbourhoods agenda with the longer term vision to transfer in 18 months the service outcomes into the Integrated Care Organisation programme.
Recommendations:	That approval is given to grant fund the core activity of Homestart and from 1 April 2017 for 18 months. The grant conditions will include a three month notice termination clause.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	Funding for these contracts is within the Section 75 pooled budget of the Integrated Commissioning Fund (£ 0.120m). The contracts provide early intervention, which support families to cope, improve confidence and build better lives for their children. Engaging with families in this way is a much more cost effective way of providing support when compared to supporting a child in need by other means (e.g. foster care). By way of comparison, the average cost per week of a local Homestart volunteer to support a child is £10.69 per week (£22.93 per week for a family), compared to £239 per week to provide foster care (based on care for a 5 year old child. A full cost benefit analysis will be undertaken during development of the future delivery model.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Single Commissioning Board has full delegation to determine this matter. The offer of grant funding to Homestart will result in the Single Commissioning Board financially supporting the action of an external organisation by means of a subsidy because the activities of that organisation contribute to our agreed policy aims

	and priorities. The grant does not contractually oblige a recipient to perform as otherwise this will amount to a contract which must be procured. The agreement can however set the requirements the recipient must follow if they do perform the services. Moreover, if services are not being performed as required, 3 months notice can be given to terminate the arrangements.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Starting Well, Developing Well and Living Well programmes for action
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention) strand of the Locality Plan
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	Due to time constraints, the report was circulated to PRG members and no comments were received.
Public and Patient Implications:	None.
Quality Implications:	There is a duty to achieve continuous improvement and value for money in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	The holistic nature of the new service will ensure that parents will receive appropriate advice and support so that they are able to maintain and maximise their health and their role as a parent and member of their community.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to this service
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information will be maintained at all times by both purchaser and provider. The purchasers Terms and Conditions for services contains relevant clauses regarding Data Management
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the providers contingency plan
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson Telephone: 342 2842 e-mail: Debbie.watson@tameside.gov.uk

1. INTRODUCTION & SCOPE

1.1 These grant conditions cover two grants for services to be provided by Homestart:

- Home visiting and befriending service (core service delivery – currently funded at £75,000.00 per annum);

- Two year old free early education entitlement for a parental engagement and participation programme (supporting the Council's statutory duty – currently funded at £45,000.00 per annum).

1.2 Homestart supports parents with young families as they learn to cope, improve their confidence and build better lives for their children. The benefits of their support include improved health and wellbeing and better family relationships.

1.3 The new statutory duty to provide a targeted offer of fifteen hours a week good quality free early education to disadvantaged two year olds came into force in September 2013. This is part of a wider range of activities aimed at improving young children's learning readiness at school age.

1.5 The Single Commissioning Board celebrates the contribution and value of volunteering in all of its diversity to individuals, communities, causes and the wider society and aims to nurture a 'volunteering friendly' economic, political and social environment within the Borough. Generally, Homestart has one hundred and fifty plus active volunteers on its database at any one time.

2. BACKGROUND – HOMESTART OLDHAM, STOCKPORT AND TAMESIDE

2.1 Homestart has been operating in Tameside since 1998, and the Council was instrumental in supporting the local organisation to set up at that time. The Council has had a productive partnership with Homestart since around 2008 delivering a home visiting and befriending service. Homestart was established for the benefit and well-being of vulnerable families in Tameside, and its uniqueness is defined in their service model of using trained and supervised volunteers to deliver agreed support interventions to families.

2.2 The service has always worked closely with the Council to proactively review its service model and make adaptations to service options in order to meet the changing needs of families locally, and the challenges faced by the locality.

2.3 Parents, carers and the wider family accessing the service offered by Homestart are typically vulnerable because they may:

- have poor physical or emotional health, or feel isolated or depressed;
- have problems with substance misuse;
- have learning difficulties;
- have disengaged from statutory services;
- be living in poor environments with very limited financial resources, poor housing or temporary accommodation and limited means of transport;
- be bringing up children on their own;
- be teenage parents;
- be experiencing domestic abuse;
- feel discriminated against because they are from black and minority ethnic communities, or because they are refugees or asylum seekers;
- have been poorly parented themselves and so have few models of good parenting;
- be experiencing particular difficulties with a child with behavioural problems;
- be caring for a child with disabilities;

- be a parent of twins or multiples;
- be looking after a child who is looked after.

2.4 Homestart has worked with the Council to redesign its service offer over the years, responding to the changing profile of family's needs being presented along with the tightening of financial resources available.

2.5 Nationally there continues to be strong government emphasis on early intervention. Early intervention and prevention in Children's Services represents an intelligent approach to spending. It requires small investments to deal with root causes, rather than the much greater costs of dealing with the after-effects. It allows us to act in a less intrusive, more cost-effective for example a preventative community parenting programme, can be save money on high cost interventions (youth crime and prison, unemployment, mental health problems and going into care) further down the line.

2.6 Evidence suggests that effective preventative intervention help to break recurring cycles of poor social outcomes, and prevent extensive and expensive responses from public services at a later stage. The aim is to shift priorities and resources from damage limitation to prevention and early intervention. It is fully accepted that this is a long-term endeavour.

2.7 In addition to the benefits for children and families from support in the early years, there is a growing body of national and international evidence to show that significant savings can be made to the public purse from effective early year's interventions. There is also a clear economic case for shifting resources into early intervention. Notably, a wide range of economic studies suggest that returns to early investment in children during the pre-birth period and first few months of life, up to the age of eight years old are high, but reduce the later the investment is initiated. Investment in early and effective interventions translates into substantial savings to the public sector.

2.8 Locally, the Early Help Strategy provides the strategic framework for the delivery of services across the borough. It highlights the overriding commitment to reduce inequalities and to narrow the gap, particularly for those children and young people at risk of poor outcomes, and recognises the key role that parents play in their children's development and understanding of the world around them.

2.9 The Home Visiting and Befriending Service delivered by Homestart over the last six years is a key strand in the borough's parenting provision and support for parent infant attachment. Service evaluation has shown that parents accessing the service become less isolated, more confident and able to cope better as parents. The fundamental purpose of the service is to improve child outcomes through effective prevention, early intervention and quality family support.

2.10 The existing service has successfully used volunteers and members of the local community in establishing contact with those families where there is often a mistrust of professionals and a reluctance to use statutory services. Working in partnership with health visitors and early years services has enabled early intervention with vulnerable families. Trained and supported volunteers, who themselves are parents, have offered support in the families' own homes and in children's centres. The volunteers have offered practical help, support and friendship in order to help prevent family breakdown and crisis. Families have received specific and targeted support and have been signposted to other services to support them making healthy life choices.

2.11 For the reasons above and the local need to reduce demand whilst building universal, community based provision into our emerging children and families offer, it is proposed that we continue to commission and develop the model with Homestart over the next 18 months.

2.12 Agreement in early September 2016 was reached to deliver a single more holistic low level family support service. Our emerging model will aim to achieve positive outcomes for children, mothers and family members who use the service and the volunteers who provide it. Specifically, the service will:

- Provide a strengths-based, empowering service for mothers, partners and family members that reduces isolation, stress and low mood during pregnancy and the first two years after birth.
- Create a family support approach that will address and support families with a range of issues' Health and wellbeing; Transition; Child Development; Parenting; Learning skills; Financial resilience; Family breakdown and Anti-social behaviour.
- Recruit and train community volunteers to work as peer supporters, providing them with necessary skills and knowledge to deliver the service and improving their personal confidence, building social capital and enhancing opportunities for further training and employment.
- Lead to improved outcomes for children; disadvantaged children will benefit particularly from high quality preschool provision and early childhood intervention.
- Will boost children's confidence and social skills, which provides a better foundation for success at school.
- Reduce demand into Early Help and Children's Social Care.

2.13 The new service will support a reduction in demand in Early Help and Children's Social Care and complement the transformation programme in 2017/18. It will also start the delivery of integrated services for Children and Families, requiring all agencies locally to understand and collaborate on arrangements for delivering a children and families offer. The work will be aligned to the Integrated Neighbourhoods agenda and build on the Integrated Care Organisation programme to date.

2.14 Home-Start's volunteer led model of early intervention and prevention is a very cost-effective form of family support:

- On average, it costs a local Home-Start £10.69 per week to support a child.
- On average it costs a local Home-Start £22.93 to support a family for a week.

3. AUTHORISATION TO EXTEND THE CURRENT GRANT ARRANGEMENTS

3.1 Authorisation is sought to extend the current grant arrangement by 18 months from 1 April 2017. This will allow time to plan, design and implement a new model that will be phased in during this period of time.

3.2 It is intended that the 18 month extension period will be used to pilot the new service model with Homestart as the supplier. Homestart is a long standing provider of services and has a desirable volunteer based delivery model that our market intelligence would suggest is unique to this provider.

3.3 The new design model will ensure alignment with the Care Together vision for integrated children and families with a longer term intention to transfer the new service outcomes into the Integrated Care Organisation programme, via a comprehensive review of the pilot. The pilot will also enable commissioners to ensure that the future budget is also correctly aligned within the supplier market and budget pressures.

3.4 Whilst the financial model has yet to be finalised, the likelihood is that the budget will be no more than the current total budget of £120,000.00 and may well be slightly less.

4. VALUE OF GRANT

4.1 The value of the grant is £120,000 for 2017/18 and £60,000 for 2018/19.

5. RECOMMENDATIONS

5.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 December 2016
Reporting Member / Officer of Single Commissioning Board	Angela Hardman, Director of Public Health and Performance, Single Commissioning
Subject:	**CONTRACT FOR THE PROVISION OF A BREASTFEEDING PEER SUPPORT SERVICE**
Report Summary:	The report outlines the current contractual arrangements for the above service and seeks to enter into a collaborative procurement with Oldham MBC to take effect once their contract with the same provider comes to an end on 30 September 2017. As a result of the collaborative approach permission is sought to extend the current contract until 30 September 2017 to align both contracts.
Recommendations:	i) That approval is given to extend the current contract from 1 April 2017 to 30 September 2017. ii) That approval is given to recommission this service jointly with Oldham MBC.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	Funding for the extension of this contract is within the Section 75 pooled budget. The proposed extension for six months at a cost of £0.057m will ensure continued compliance with the Greater Manchester Early Years Delivery Model and the Greater Manchester Early Years Starting Well Strategy. The proposed extension will also ensure alignment with Oldham MBC's contract and will enable the service to be jointly commissioned from 1 October 2017. Commissioning the new contract jointly with Oldham MBC will provide scope for operational and financial efficiencies which will be quantified within the development of the revised contract specification.
Legal Implications: **(Authorised by the Borough Solicitor)**	This is a decision wholly within the delegation of the Single Commissioning Board. It is appropriate to vary contracts where there are exceptional circumstances to justify such a course of action and it will not contravene any legal obligation. Public Health services are subject to a light touch under the Public Contracts Regulations 2015 and the contract falls below the threshold of requiring procurement. However, in the interests of transparency and value for money it is expedient that a procurement exercise is undertaken as set out in the report.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Starting Well, Developing Well and Living Well programmes for action
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention) strand of the Locality Plan
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities;

	• Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	Due to time constraints, the report was circulated to PRG members and no comments were received.
Public and Patient Implications:	None.
Quality Implications:	There is a duty to achieve continuous improvement and value for money in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	The nature of the service will ensure that parents will receive appropriate advice and support so that they are able to make an informed decision about breastfeeding and the benefits to the long term health and development of their child(ren)
What are the Equality and Diversity implications?	Clearly, the funding is focused on one particular section of the community, breastfeeding women. However, the proposals do not discriminate against other protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to this service.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information will be maintained at all times by both purchaser and provider. The purchasers Terms and Conditions for services contains relevant clauses regarding Data Management
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the providers contingency plan.
Access to Information :	The background papers relating to this report can be inspected by contacting Nick Ellwood, Planning & Commissioning Officer: Telephone: 07976931066 e-mail: nick.ellwood@tameside.gov.uk

1. INTRODUCTION & SCOPE

1.1 Breastfeeding provides short and long-term health benefits to both mother and baby, including promoting the emotional attachment between them both; and contributes significantly to reducing health inequalities.

1.2 The Breastfeeding Peer Support Programme contributes to promoting a social and cultural shift where breastfeeding is viewed as the conventional way to feed a baby. The Department of Health recommend exclusive breastfeeding for the first six months as providing optimum nutrition for babies with the gradual introduction of solid food after this time in tune with the baby's developmental progress.

1.3 Parents can benefit from early, evidence-based information in order to enable them to make an informed infant feeding choice. Proactive, intensive, and early skilled support in breastfeeding management helps to prevent any problems and/or barriers that lead to mothers stopping breastfeeding earlier than they or their baby would have wished.

1.4 NICE Guidelines (Nice Public Health Guidance 11 March 2008), recommend the commissioning of a local, easily accessible breastfeeding peer support programme where peer supporters are part of a multidisciplinary team. The recommendation is that peer supporters are trained through an externally accredited training programme; contact new mothers directly within 48 hours of their transfer home (or within 48 hour of a home birth) and offer mothers on-going support according to their individual needs.

1.5 The breastfeeding peer support service works in close partnership with midwifery, health visiting and children centre services by helping develop accessible pathways and promoting best practice breastfeeding management through UNICEF Baby Friendly full accreditation standards.

1.6 Homestart, Oldham, Stockport and Tameside (HOST) continues to provide the service following a waiver decision agreed in February 2016.

1.7 The service enables universal support for Tameside for new breastfeeding mothers and their families as set out through the Greater Manchester Early Years Delivery Model and the Greater Manchester Early Years Starting Well Strategy. This strategy acknowledges the unique challenge of the Early Years system with the diverse range of stakeholders that include NHS services, Local Authority children's services, schools, private early years settings and wider stakeholders.

1.8 The Starting Well Greater Manchester commissioning group and the Public Health Population Health Commissioners Group undertake specific work to develop a whole systems approach to Public Health commissioning as required by the Theme One Executive Group, and in line with the Taking Charge Strategy transformation themes and the Population Health Delivery Plan. It is through this work that opportunities have been identified for more collaborative commissioning approaches, across districts and alignment with Theme One's priorities.

1.9 Hence, the intention going forward is to jointly commission this service in partnership with Oldham MBC. Homestart currently provide a Breastfeeding service for Tameside and Oldham. Other areas of Greater Manchester have shown an interest in joint commissioning arrangements in the future.

1.10 In order that the service can be jointly commissioned, Tameside will need to align the contract with Oldham's, which has an end date of the 30 September 2017.

1.11 Aligning contracts and jointly commissioning a new service will provide scope for efficiencies which will be identified as the specification across the two Boroughs is agreed.

1.12 Public Health has recently completed a Breastfeeding needs assessment to inform the new specification which will be a targeted with an integrated approach.

2. AUTHORISATION TO PROCEED

2.1 Approval is sought for a contract extension beyond the current contract end date, 31 March 2017.

2.2 A further extension until 30 September 2017 is requested for the Breastfeeding Peer Support Service provided by Homestart to allow the necessary time required to plan and undertake a joint procurement exercise with Oldham MBC with the new contract to commence 1 October 2017. Tameside MBC will be the lead commissioner.

2.3 Authorisation is also required to go out to tender for this service. The financial envelope would be in the region of current annual spend; £116,250.

3. VALUE OF CONTRACT

3.1 The value of the contract is £116,250 per annum and hence an additional six months will cost £57,437. This contract value was reduced in 2016/17 to contribute to Public Health grant reductions imposed on the Council.

3.2 The contract includes a three month termination on notice by either party.

4. GROUNDS UPON WHICH WAIVER /AUTHORISATION TO PROCEED IS SOUGHT

4.1 Going out to the market with a six month contract to cover the period 1 April – 30 September 2017 is not viable either for potential tenderers or for the Council in terms of securing best value. A service commissioned jointly with Oldham MBC will deliver a degree of efficiencies whilst cementing partnership working across Great Manchester.

4.2 Given this, extending the current contract to align it with Oldham's, allows time to plan and undertake a full market testing.

5. RECOMMENDATION

5.1 As set out on the front of the report.